How Two Doctors May Revolutionize Health Care: The SimpleCare Story — centerspread

Health Care News

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STATE RISK POOLS UNDER THE GUN

Managing Editor's note: In August 2001, a report titled "Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools," written by Lori Achman and Deborah Chollet of Mathematica Policy Research, Inc., was produced under a grant from The Commonwealth Fund.

The following is a summary of a well-documented 10-page rebuttal of the report by Bruce Abbe, vice president of public affairs for Communicating for Agriculture (CA). Abbe is editor of CA's annual directory on risk pools, "Comprehensive Health Insurance for High Risk Individuals—A State-By-State Analysis."

BY BRUCE ABBE

According to "Insuring the Uninsurable: An Overview of State High-Risk Insurance Pools," by Lori Achman and Deborah Chollet, state high-risk pools tend to have premiums that are too high, benefits that are too limited, aren't sufficiently promoted, and serve only a small fraction of the high-risk population.

The report, produced with funding from The Commonwealth Fund, often uses selective information about one or two state programs to paint negative conclusions about the state risk pool system as a whole. The authors frequently criticize risk pools for what are essentially normal benefits and characteristics of the individual health insurance market—of which these programs are a part.

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Pediatrician Wilma Bausas examines Jonathan Valdez, 2, during his visit to the Centro de Salud Familiar La Fe, Inc. health clinic in El Paso, Texas. Texas ranks second to last (49th out of 50 states) in the nation in the percentage of children without health insurance. About 1.4 million children in Texas are uninsured. Photo: Joe Raedle/Newsmakers

Federal Tax Credits Would Reduce Uninsured by 85%, Studies Say

Two studies point to the benefits of refundable tax credits

BY GREG SCANDLEN

People with employer-provided health insurance receive a substantial tax saving because this benefit is not taxed as income. By contrast, people who buy their own insurance must do so with after-tax dollars.

There are proposals in both the House and Senate to remedy this inequity through refundable tax credits for those who buy their own health insurance. (A refundable credit is one that is paid regardless of whether the recipient paid that much in taxes.)

Both George W. Bush and Al Gore endorsed the idea during the Presidential campaign, and members of Congress as politically diverse as Democrat Pete Stark and Republican Dick Armey support some version of it. Most of the proposals suggest a credit of about $1,000 for an individual and $2,500 for a family.

Would a refundable tax credit prompt the uninsured to buy a policy?

Two studies released in September 2001 examine the impact refundable tax credits might have on the uninsured who are potential buyers of individual policies. Both use the online insurance broker eHealthInsurance to capture possible premium rates, and both assume a refundable tax credit of $1,000 for an individual policy. Everything else about the two studies differs: the methodology, the authors, the scholarship, and the media hype.

One study is a scholarly work, the other a political tract that contends many of the uninsured would get little or no help. Yet, the inescapable conclusion drawn from both is that a $1,000 refundable tax credit would lower the numbers of uninsured in the United States.

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Defined Contribution Gains Momentum

BY CONRAD F. MEIER

According to a recent study by Conning & Company, an investment management and research firm headquartered in Hartford, Connecticut, the U.S. is at the beginning stages of a significant change in how health insurance is delivered to most Americans.

The study, "Defined Contribution Approaches to Health Care Benefits: The Long Awaited Answer?" was released on November 26, 2001 and written by Conning Vice President Samuel Levitt.

"We now see the kind of incremental approaches in health care benefits that signal a shift toward defined contribution," explained Levitt. "And, we also see clearly that employ-

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MY TURN

AN EDITORIAL BY CONRAD MEIER

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Matthews Named Acting Director of CAHI

The Board of Directors of the Council for Affordable Health Insurance (CAHI) announced on November 15, 2001 that Merrill Matthews Jr., Ph.D., has joined CAHI as Acting Director to lead its health reform efforts.

Earlier that year, Matthews was named senior fellow in health policy at The Heartland Institute and became an assistant editor for its newest publication, *Health Care News*.

Bill O'Connor, chairman of the CAHI Board of Directors, made the announcement. "Dr. Matthews' extensive experience in health policy makes him an excellent choice to lead CAHI as we meet the challenges of ensuring that all Americans have access to affordable health insurance," O'Connor noted. "Merrill's strong personal commitment to free markets and choice mirrors CAHI's, and under his leadership we expect to continue as the leading advocate for a free and competitive health care marketplace."

Matthews replaces Nona Wegner, who has led the association since 1999. Wegner announced in 2001 that she would be joining Citizens for Better Medicare, and she has been working with that organization in a part-time capacity.

CAHI is a research and advocacy association of insurance carriers active in the individual, small group, medical savings account, and senior citizen markets. CAHI's membership includes more than 40 insurance companies, small businesses, physicians, actuaries, and insurance brokers. Since 1992, CAHI has actively advocated market-oriented solutions to the problems facing America's health care system.

For more information…

WWW Contact Kelly Loussedes, CAHI's director of public affairs, at loussedes@cahi.org, or visit the CAHI Web site at **www.cahi.org.**

Irradiation: It's Not Just for the Mail

BY ALEX AVERY

After Sen. Tom Daschle's office was the target of an anthrax letter last fall, he declared all mail should be irradiated "as soon as possible" to make the postal system safe for workers and the public. Irradiation would likely have prevented the four mail-related anthrax deaths that have occurred to date.

But irradiation could do far more, preventing literally thousands of American deaths and millions of non-fatal infections that attack Americans each year via the food supply. Standing in the way of this great benefit is a dedicated group of anti-technology activists successfully scaring consumers away from a food safety solution by claiming irradiation itself is a food safety problem.

With irradiation receiving long-overdue recognition as a public health tool, now is the perfect time to consider wider use of irradiation to treat foods, especially higher-risk foods such as ground meats and alfalfa sprouts.

White House and congressional mail is already being trucked to irradiation facilities for treatment prior to delivery, and the postal service is buying irradiation technology for installation at strategic postal facilities around the country. This program could eventually be instituted nationwide.

U.S. Slow to Respond

In awful contrast, the U.S. government dithered for years over approval of food irradiation when many other countries allowed irradiation of foods decades ago. The U.S. Food and Drug Administration didn't approve irradiation of red meat and pork to prevent *E. coli* and *salmonella* until 1997, years after the Jack-in-the-Box tragedy.

While the anthrax scare has so far involved a handful of deaths and a few dozen infections, the U.S. Centers for Disease Control and Prevention estimates food microbes cause more than 75 million illnesses, kill 5,200 Americans, and hospitalize more than 300,000 every year.

Food irradiation is now approved in more than 40 countries. The American Medical Association, the American Dietetic Association, and literally dozens of respected health and medical organizations around the world endorse its use to treat food. The World Health Organization calls buying irradiated food one of its 10 Golden Rules of Food Safety. There is simply no doubt whatsoever about the safety and effectiveness of food irradiation.

Some argue the problem is too many bacteria on our farms and in our farm animals. "Clean up the animals and factory farms before you start messing with my food," they demand. But it is impossible to produce microbe-free foods.

Crops and livestock are produced in the great outdoors, where bacteria and fungi thrive. Most pathogens co-evolved with our animals and are naturally present in the digestive tracts of livestock.

Nor is so-called factory farming the problem. A recent study in Denmark found that 100 percent of organic, free-range chicken flocks tested positive for *Campylobacter* bacteria, compared to only one- third of conventional flocks.

Why the Delay?

Given the heavy human toll, why has it taken so long for the government to approve irradiation of foods?

> **"[T]he U.S. Centers for Disease Control and Prevention estimates food microbes cause more than 75 million illnesses, kill 5,200 Americans,and hospitalize more than 300,000 every year."**

Mainly, it is the result of public fear, whipped up by so-called consumer groups and other self-appointed elements of the fear industry. These groups have misrepresented food irradiation for decades, using the all-too-willing media to scare the public about mythical irradiation dangers. Yet study after study finds food irradiation not only safe, but safety-enhancing.

The anthrax scare may have finally demonstrated to the public the difference between real and imaginary hazards.

A year ago, barely 10 percent of consumers said they would buy irradiated foods if they were available. A new Porter Novelli survey conducted after the anthrax scare shows that more than half of consumers polled said the government should require irradiation to ensure a safe food supply.

Earlier this year, two nanny groups, The Center for Food Safety and Public Citizen, warned that further FDA approvals of irradiation "would amount to a serious potentially scandalous error in judgment." The true error in judgment would be continuing to listen to the activists, rather than to public health experts and consumers.

Alex Avery is director of research at the Hudson Institute's Center for Global Food Issues in Churchville, Virginia. This article first appeared December 26, 2001, in The Washington Times *and is reprinted here with permission.*

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You are invited to participate in an online discussion list dealing with many of the issues we report on here. To check it out, send an e-mail to HealthBenefitsReform-subscribe@yahoogroups.com. Later on, if you want to drop off, just send an e-mail to HealthBenefitsReform-unsubscribe@yahoogroups.com.

Confused in Canada

Ontario's *The National Post* recently surveyed Canadian public opinion on a host of health care issues. The results are a fascinating mix, including the following tidbits:

- Only 10 percent of Canadians think their health care services have improved "over the last couple of years," while 62 percent think they have gotten worse. This is an improvement from the last survey (February 1999), when the numbers were 6 percent and 79 percent, respectively.
- When asked which country has "superior" medical technology, 57 percent said the U.S. and only 14 percent said Canada.
- When asked who is doing the best job in health care, the top two categories were doctors in general practice (27 percent) and registered nurses (20 percent). When asked who is doing the worst job, the top two categories were the provincial health ministry (24 percent) and the federal department of health (17 percent).
- When asked if it was a "good idea" to add certain services to the system, 90 percent supported more home care, 84 percent supported more "walk-in clinics," and 73 percent supported going to nurse practitioners rather than doctors "at the first sign of illness."
- When asked if it was "important" that Canada continue to provide "free access to a fairly wide range of services for all or almost all," 88 percent said it is and only 9 percent said it is not.
- When asked if it was "important" that "provincial governments exercise central control over the entire health care system in great detail," 71 percent said it is and only 24 percent said it is not.
- Similarly, 60 percent disagreed with the idea that "patients would be treated better if the money flowed through them." Yet 50 percent supported the idea of considering Medical Savings Accounts, while 45 percent did not.

Source: "Special Report: State of Health Care," *The National Post*, November 17, 2001. http://quarterlyreport.nationalpost.com

Ontario Premier Misses Opportunity

The *Ottawa Citizen* expressed disappointment that Ontario Premier Mike Harris isn't doing more on health care in his waning days in office. In an editorial, the paper criticizes him for doing nothing more than asking the federal government to spend more money, when he could be suggesting innovations like MSAs.

Source: "A Missed Chance for a Healthy Exchange of Ideas," *The Ottawa Citizen*, November 27, 2001.

Alberta Health Reform Report

In Alberta, a new report on health care reform "won't fly in the face" of the Canada Health Act, according to the *Calgary Sun*. The article says a draft of the report included raising premiums, adopting MSAs, and taxing benefits as possible solutions to rising costs. Provincial Health Minister Gary Mar is encouraged that federal Health Minister Allan Rock has recently said the Canada Health Act "wasn't the Bible" and may be subject to modernization.

Source: Nova Pierson, "No Major Health Act Fights on the Horizon," *The Calgary Sun*, November 17, 2001.

Heart Surgeon Tells Canadians to "Stop Pretending"

The *Toronto Star* profiles Dr. William Keon, one of Canada's top heart surgeons, who has been serving on a legislative committee looking at health reform in Canada.

The committee, chaired by Senator Michael Kirby, has released a report urging Canadians to look at reforms such as hospital user fees, MSAs, more private clinics, and a tax on received medical services.

The article says Dr. Keon is not very comfortable with politics or ideology, but he sees profound problems in a system that absorbs 44 percent of Ontario's total government spending (up from 33 percent five years ago), but still has problems that get worse every year.

"He thinks (Canadians) owe it to themselves and their children to stop pretending the health care system is fine, or temporarily indisposed," the article says.

Source: "A Doctor's Worried Plea," *Toronto Star*, November 10, 2001.

Ontario Hospitals Want Honest Debate

The Ontario Hospital Association is also worried that Canadians are in a state of denial, according to the *Ottawa Citizen*. The group commissioned a poll that found most Canadians oppose user fees, MSAs, competition between hospitals, and reducing coverage for wealthier citizens. Yet the poll also found only "lukewarm" support for the current system.

All this frustrates OHA head David MacKinnon, who is quoted as saying, "We just have to get off that business that whenever anybody pokes his head above the trench to put forward an idea, somebody takes a shot at him or her. ... If we're all bounded by our own ideologies and preconceptions we'll fail."

Source: David Rider, "Hospitals Urge Open Debate," *The Ottawa Citizen*, November 7, 2001.

Alberta Taxpayers "At Breaking Point"

Back in Alberta, the head of the provincial reform commission, Don Mazankowski, testified before Senator Kirby's national commission that, "The burden of taxation on Albertans is almost at the breaking point."

According to an article in the *Edmonton Journal*, Mazankowski said "Alberta must consider increasing health care premiums and making patients pay for medical procedures currently covered by medicare." But union leaders and liberal critics called such talk a "betrayal" and accused both Kirby and Mazankowski of being associated with businesses that would profit from a break-up of Canada's universal coverage system.

Source: Shawn Ohler, "Mazankowski Proposes Patient-Pay Health Care," *Edmonton Journal*, October 18, 2001.

Health Care Will Consume 53 Percent of B.C. Budget

Senator Kirby also made an appearance in Vancouver, where he told a symposium that British Columbia is on its way to spending 53 percent of the provincial budget on health care.

An article in the *Vancouver Sun* says British Columbia is already embracing private/public partnerships for new hospitals and considering user fees and supplemental private insurance. It cites Premier Gordon Campbell as saying "most reformers agree that medical services should be free to the poor and less so for the middle class and wealthy."

Source: Pamela Fayerman, "B.C. Patients Told They'll be Paying More," *Vancouver Sun*, October 23, 2001.

Crain's: Defined Contribution is "Next Big Idea"

Crain's New York Business included an article about Defined Contribution, which it calls "the next big idea in health care coverage."

The piece focuses on Novartis, which has signed up with Lumenos for 2002 enrollment. Novartis spokesman Bill Flannery is quoted as saying "It's the first step in changing the company's entire philosophy about health coverage." The article says the various consumer-driven companies can expect enrollment of about 500,000 employees in 2002.

Source: http://www.crainsny.com/article.cms?articleId=15081&a=a&bt=Novartis

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas. To sign up for his free weekly e-newsletter, Scandlen's Health Policy Comments, *log on to www.ncpa.org/sub/. For back issues of the newsletter, go to http://www.ncpa.org/sub/shpc/. Scandlen can be contacted by email at GMScan@aol.com.*

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Health Care and the War on Drugs

Editor's Note: The War on Drugs is rarely discussed in the context of health care reform, yet treating drug abuse as a crime rather than a health problem is costing the U.S. $40 billion a year. Two medical doctors ask if it isn't time to reconsider.

BY DR. MICHAEL GLUECK AND DR. ROBERT J. CIHAK

"Don't you know there's a war on?"

So ran one of the more popular admonitions of World War II. It meant, in effect, "What you're doing ain't exactly contributing to the effort, so you best mend your ways."

The principle applies today. It's time for this country to mend a number of its ways that no longer contribute (if ever they did) to the common defense and general welfare. Among them: the so-called War on Drugs.

Time to Call it Off

We favor decriminalizing drug possession and use, starting with marijuana. But before we explain why, let's review how these items got criminalized in the first place.

A century ago, all drugs were legal . . . and the resulting human wreckage littered the landscape. A generation of Civil War veterans was addicted to morphine; countless middle-class ladies dosed away their unhappiness with laudanum (an opium derivative); Coca Cola was laced with cocaine; and an unregulated patent medicine industry used addictive substances to "treat" everything from impotence to flatulence.

According to Philip Gold, cultural historian and senior fellow at Seattle's Discovery Institute, "Progressive Era reformers allied with the emerging medical profession and the AMA to attack the problem, both using the issue to advance their own larger agendas."

"Of course, advocating legalization is not the same as encouraging use. One can, for example, support keeping sky diving and cigarette smoking legal without encouraging people to do them. In fact,we discourage our patients and readers from smoking cigarettes; in our opinion, the health risks exceed the benefits. But we certainly don't propose outlawing smoking."

Reformers seeking to create what's now known as the "nanny state" got drug abuse added to their list of public health concerns. Doctors reined-in the patent medicine industry and garnered a monopoly on the prescribing of drugs. By the 1930s, it was illegal to possess any number of "controlled substances" without a doctor's OK.

For and Against Legalization

The issue resurfaced in the 1960s, and the positions of both sides froze into their pre-September 11th, patently unpersuasive forms.

Arguments in favor of legalization ranged from "it's my body and I'll wreck it if I choose" (and who pays your insurance?) to the more common-sense notion that criminalizing drugs turns users into criminals, both by non-violent personal use and by the often-violent crimes users commit to pay for their habits.

Arguments against legalization generally drew on the basic nanny-state mentality: "Everything good should be a right; everything bad should be a crime." Any number of religious objections to "defiling the temple that is the human body" also came into play.

Also popular was the argument that marijuana use leads to harder drugs, the result of some fun with numbers. While 90 percent of hard drug users may have started on marijuana, that *doesn't* mean 90 percent of marijuana users move on to harder drugs. "When war is declared, the truth is the first casualty." (Arthur Ponsonby)

Only occasionally did people bother to ask whether the "war" on drugs was working, and at what cost.

Gary Becker, a Nobel laureate in economics, has. In a September 2001 *Business Week* article, he noted the United States now spends $40 billion a year fighting the "war on drugs." Drug offenders, from kingpins to yuppies to derelicts, account for 30 percent of all inmates in the burgeoning prison population.

The Libertarian Party, in a November 30, 2001 news release, added that in 2000 alone, police arrested 734,498 people for marijuana violations (up from 704,812 the year before). Of these, nearly 90 percent were charged only with possession.

Dr. Charles Tannock, a British psychiatrist and

DEFINED continued from page 1

ers, insurers, and employees all have something to gain from this shift. It's a combination that is gaining momentum in the marketplace, and that stands a good chance of controlling the runaway cost of health care for the first time. The question is how far we will go, and how fast benefits will shift."

The movement toward defined contribution (DC) has been reported frequently in *Health Care News*. Free-market advocates of health care reform see DC as an important step toward restoring freedom of choice and financial stability to the nation's health care system.

Dr. Stephen Barchet, manager of the Defined Contribution Project at the Evergreen Freedom Foundation, explains, "A defined contribution approach to health care creates a new, more sustainable financial framework for an employer seeking to provide its employees with health benefits. This framework establishes clearly and predictably how much the employer will contribute to benefits."

"In its fullest expression," says Barchet, "the defined contribution also distances employers from health plan selection. It permits employees to directly control the range of health plans they may consider, producing a real sense of ownership over their eventual plan choice." (See "The Defined Contribution Health Benefit: A Practical Primer," *Health Care News*, August 2001.)

The Essence of DC

The Conning study identifies three attributes that form the core of the defined contribution model:

- Employers will contribute a fixed or defined amount of money for each employee.
- Employees will be free to purchase insurance benefits from the provider of their choice through the individual market, paying whatever they want at or above the employers' contribution.
- Employer and employee contributions alike will be excluded from taxable income.

"Defined Contribution is attractive to employers because it caps costs and keeps them in the benefits business, not in the healthcare business," said Levitt.

Greg Scandlen, senior fellow in health policy at the National Center for Policy Analysis, covers defined contribution for *Health Care News*. He agrees with Levitt's positive assessment of the DC movement.

Citing last year's study from Booz-Allen Hamilton, Scandlen reports "the firm is focusing more on the opportunity presented to financial institutions by a change to defined contributions. In their analysis, 'The Next Trillion Dollar Opportunity,' authors Gary Ahlquist, Phillip Lathrop, and David Knott point out that DC will create 50 to 100 million new individual investment accounts, and that financial institutions will probably service the

For more information…

WWW The full text of Dr. Stephen Barchet's introduction to defined contribution, "The Defined Contribution Health Benefit: A Practical Primer," is available from the Evergreen Freedom Foundation for a suggested contribution of $25. An online ordering form can be found at **http://effwa.org/website/DCHBorderform.htm.**

More information about the November 2001 Conning & Company study, "Defined Contribution Approaches to Health Care Benefits: The Long Awaited Answer?" is available from the company's Web site at **www.conning.com.** The full text of the study can be purchased for $575 at the Web site, or by calling 888/707-1177 or 860/520-1521.

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member of the European Parliament, wrote in the November 21, 2001 edition of *Wall Street Journal Europe* that "the toxicity of the drug itself [marijuana] is probably smaller than that of aspirin, in terms of lethal dose." Marijuana, unlike heroin, is not physically addicting.

Of course, advocating legalization is not the same as encouraging use. One can, for example, support keeping sky diving and cigarette smoking legal without encouraging people to do them. In fact, we discourage our patients and readers from smoking cigarettes; in our opinion, the health risks exceed the benefits. But we certainly don't propose outlawing smoking.

After September 11

It's time for Americans to recognize that today's international drug smugglers have little in common with yesterday's Al Capone. Capone and his contemporaries were violent, dangerous thugs. Today's drug smugglers are basically in it for the money.

Drug trafficking funds any number of terrorist organizations. Every American who buys illegal drugs, directly or indirectly, gives aid and comfort to this nation's enemies.

Law enforcement officials have far more important things to do than fill the nation's jails and courts with petty drug offenders. And it's not just that the resources are needed to track down terrorists. Since September 11, many cities have seen an upsurge in major crimes committed by people who know that, with so many police off doing homeland security work, their chances for a successful murder, burglary, or rape are greatly enhanced.

Nancy Reagan popularized the "Just say No" approach to drug use. It's still valid, but we would add, "Don't you know there's a war on?"

It's time we admit we are in World War III: against 60 countries and thousands of enemies within our midst. Our drug war contributes nothing to that far more important cause.

Dr. Michael Arnold Glueck writes extensively on medical and legal reform issues. Dr. Robert J. Cihak is the immediate past president of the Association of American Physicians and Surgeons (AAPS).

bulk of these accounts."

Defined contribution approaches benefit all health care stakeholders, according to Levitt.

"The erosion of ERISA protection has made employers potentially more vulnerable to legal risks, something they don't want. For the insurers, [Defined Contribution] has made it likely that they will be able to offer more tailored products without government restrictions. For employees, it will mean more choice in plans and coverage, at least once the insurers have made the transition to large individual markets. This, of course, is the biggest bottleneck in the process."

Learning from Experience

The seed for defined contribution health care benefits was planted more than a decade ago, when employers shifted their retirement plans from defined benefit to defined contribution models.

Rather than offer their employees a fixed income at retirement age (defined benefit), most employers offer regular payments into an employee-directed plan (defined contribution), such as a 401(k), leaving the choice of investment options and performance to the employee.

Is Legal Marijuana on the Horizon?

Ten events in 2001 suggest that legal marijuana may be just around the corner. Is the medical community ready for the consequences?

BY ALLEN ST. PIERRE

1 Europe Goes to Pot: Great Britain, EU Abandon Marijuana Prohibition

UK officials branded marijuana prohibition an endangered species in 2001, announcing in October that police would no longer arrest individuals for marijuana possession, and that marijuana would be federally reclassified as a "soft" drug. Britain's new policy, expected to be formalized by Spring 2002, is similar to those of its European Union neighbors, most of whom no longer criminalize the use of marijuana or other drugs.

2 Zogby Poll Finds 61% of Americans Oppose Pot Prohibition

Americans' opposition to the government's war on marijuana rose significantly in 2001, according to a national Zogby poll of 1,024 likely voters commissioned by the NORML Foundation.

Sixty-one percent of respondents said they opposed arresting and jailing nonviolent marijuana smokers in light of the increased threat of terrorism since September 11. In addition, two-thirds (67 percent) said they opposed the use of federal law enforcement agencies to close dispensaries that distribute medicinal marijuana in states that have legalized its use.

3 Canada Legalizes Medical Marijuana

Canada became the first country in the world to sanction the use and cultivation of medical marijuana by qualified individuals, enacting nationwide regulations in August that enable patients and their caregivers to legally grow and possess medicinal cannabis.

Ironically, Canada's policy change came mere months after the U.S. Supreme Court affirmed federal provisions in the Controlled Substances Act defining marijuana as having "no currently accepted medical use."

4 Supreme Court Rules on Medical Pot Distribution

The U.S. Supreme Court ruled in May that patient support groups who grow and supply medical marijuana for the seriously ill are not exempt from federal law by the defense of "medical necessity." Contrary to popular interpretation, the ruling did not strike down or invalidate state laws legalizing the medical use of marijuana by individual patients—a separate issue that was not before the Court.

5 Nevada Reduces Nation's Toughest Pot Laws to a Fine-Only Offense

Nevada's marijuana laws received a long-overdue overhaul in 2001, as legislators reduced marijuana possession from a four-year felony to a fine-only offense and enacted legislation legalizing marijuana's medical use. The legislature was the first in 24 years (and twelfth overall) to eliminate jail time and criminal records for minor marijuana offenders, and the ninth state since 1996 to legalize the use of medical cannabis under a doctor's supervision.

6 Pot Arrests For Year 2000 Hit All Time High

Former President Bill Clinton's parting shot to the marijuana community was one for the record books.

According to the FBI's Year 2000 Uniform Crime Report, police arrested an estimated 734,498 persons for marijuana violations in 2000, the final year of the Clinton regime. The total is the highest ever recorded by the FBI, and represents just under half of all drug arrests recorded so far this millennium.

7 DEA Wages War on California's Medical Pot Clubs

In a major federal crackdown on California's medical marijuana providers, law enforcement officials in fall 2000 raided a pair of state medical marijuana dispensaries: the Los Angeles Cannabis Resource Center in West Hollywood and the California Medical Research Center in Cool.

8 New Mexico Governor Calls for Pot Legalization at NORML Conference

Challenging the myth that marijuana-law reform is the "third rail" of politics, two-time Republican Governor Gary Johnson called for marijuana's legalization at NORML's annual conference in Washington, DC. "I'm for marijuana legalization," he told attendees during NORML's luncheon address, broadcast live on C-SPAN. "I think that decriminalization turns its back on half of the problem."

> **"Sixty-one percent of respondents [to a Zogby poll] said they opposed arrestingand jailing nonviolent marijuana smokers in light of the increased threat of terrorism since September 11."**

9 Bipartisan Bill to Legalize Medical Pot Introduced in Congress

For the first time in nearly 20 years, politicians from both sides of the aisle—Reps. Barney Frank (D-Massachusetts) and Ron Paul (R-Texas)—joined forces to introduce legislation in Congress to legalize medical marijuana. Their bill, H.R. 2592 (the "States' Rights to Medical Marijuana Act"), was referred in mid-July to the House Energy and Commerce Committee, Subcommittee on Health, which has yet to act on the measure.

10 DEA Okays State-Sponsored Medical Marijuana Trials

Ending nearly two decades of de facto prohibition on medical marijuana research, the Drug Enforcement Administration in November approved three state-sponsored patient trials on the therapeutic potential of smoked marijuana. The trials will begin early this year at the University of California's Center for Medicinal Cannabis Research (CMCR). Eight other FDA-approved protocols remain pending before the DEA.

Allen St. Pierre is executive director of the National Organization for the Reform of Marijuana Laws (NORML). Contact NORML at http://www.norml.org.

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RELIEF continued from page 1

The Scholarly Study

"Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured," a study by economists Mark Pauly and David Song of the University of Pennsylvania and Bradley Herring of Yale University, was published and released without much fanfare by the National Bureau of Economic Research (NBER) as Working Paper #8457.

Unlike previous works by the authors and other scholars, the NBER study does not estimate purchasing decisions based on a premium that is the average of all available premiums. Instead, it notes that "no rational purchaser who has obtained price quotes would choose to pay the average or median price. Rather, the buyer would pay the lowest price (or something close to it)."

The authors also reject the idea that premiums can be judged "affordable" or "unaffordable" based solely on the income of the purchaser. The value of the expected benefit must be considered as well. For that reason, people with higher health risks would be more likely to purchase coverage, or pay more for it, than would a low-risk individual with the same income.

The NBER study uses a sample population from the Community Tracking Study, conducted every two years by the Center for Studying Health System Change, to estimate how people would respond to a $1,000 tax credit, given their income, location, sex, age, and smoking behavior. It then compares these populations to the premiums available online for a policy with no more than a $1,000 deductible.

The NBER authors found that premium data were nonexistent or limited in nine states that have adopted community-rating laws requiring that all policyholders be charged the same premium regardless of their health status, and eliminating or compressing age-based premiums.

Still, as the figure shows, using one methodology the study found that, with a $1,000 tax credit:

> **"[T]he inescapable conclusion ... is that a $1,000 refundable tax credit would dramatically lower the number of uninsured in the United States."**

- As many as 85 percent of the uninsured would buy health insurance with a $1,000 deductible, a 20 percent coinsurance requirement, and a $2,000 limit on out-of-pocket spending.
- More than 25 percent of the uninsured could get the policy without paying anything beyond the tax credit.
- Another 25 percent would have to pay no more than $168 a year beyond the tax credit.

Using different assumptions, the study finds that between 50 and 75 percent of the uninsured population could purchase individual coverage for free with a $1,000 tax credit if they chose from the 10 percent of policies with the lowest available premiums. Even the lowest 25 percent of available premiums would be free to at least one-quarter of the uninsured, with half of the uninsured paying no more than $252 a year in addition to the tax credit.

The Political Tract

The other September study was released at a press conference by FamiliesUSA, a liberal advocacy group. Called "A 10-Foot Rope for a 40-Foot Hole," this report does not identify its authors and is clearly intended as a political document rather than a serious attempt to advance understanding. In fact, every element of the report is chosen for calculated political effect. For instance:

- The study looks only at 25 states, including six of the community-rating states with little or no data.
- It considers only what insurance policy a 25-year-old woman and a 55-year-old woman could obtain.
- Rather than testing what people might actually purchase, it looks only at the most popular plan offered to federal employees—a Blue Cross Blue Shield plan with a $250 deductible and minimal co-payments for doctors' visits and prescription drugs. It calls anything less generous "substandard."

The FamiliesUSA report examines what benefits can be purchased for the $1,000 tax credit and how much the premium is for what it describes as a "standard" plan. Among the report's conclusions:

- "$1,000 plans are not always available for healthy, non-smoking, 25-year-old women." But it found they could get coverage for $1,000 in all but six states, five of which are community-rating states, where the market is in chaos.
- "$1,000 plans for healthy, non-smoking 25-year-olds in the states where they are available are substandard." This is another way of saying one can't buy the federal Blue Cross Blue Shield plan in the individual market for $1,000 a year—hardly surprising, since the federal premium for that plan is $3,142 a year.
- "Standard health insurance plans are not always available for healthy, non-smoking, 25 year-old (or 55-year old) women." It cites four states, three of them community-rating states, which have very few options left.

What FamiliesUSA actually found is that health insurance is more affordable for younger people than for older people, and that younger people could purchase good coverage for $1,000 per year in almost all the states. This is very useful information, since most of the uninsured are young.

According to the Census Bureau, out of a total uninsured population of 38.7 million, 30.7 million (79 percent) are under 45 years old. This lends credence to the conclusion of the Pauly study, that something approaching 85 percent of the uninsured would be able to purchase coverage with a $1,000 tax credit.

Conclusion

Even though the FamiliesUSA study is intended to demonstrate that the $1,000 tax credit is a bad idea, it actually confirms the credit would enable a large number of currently uninsured people to purchase health insurance with little or no out-of-pocket cost.

The insurance one can buy with a tax credit would not be as generous or as comprehensive as most employer plans, but both studies find it could attract large numbers of those who are now uninsured. The only states where the tax credit apparently would have little impact would be states with community-rating laws.

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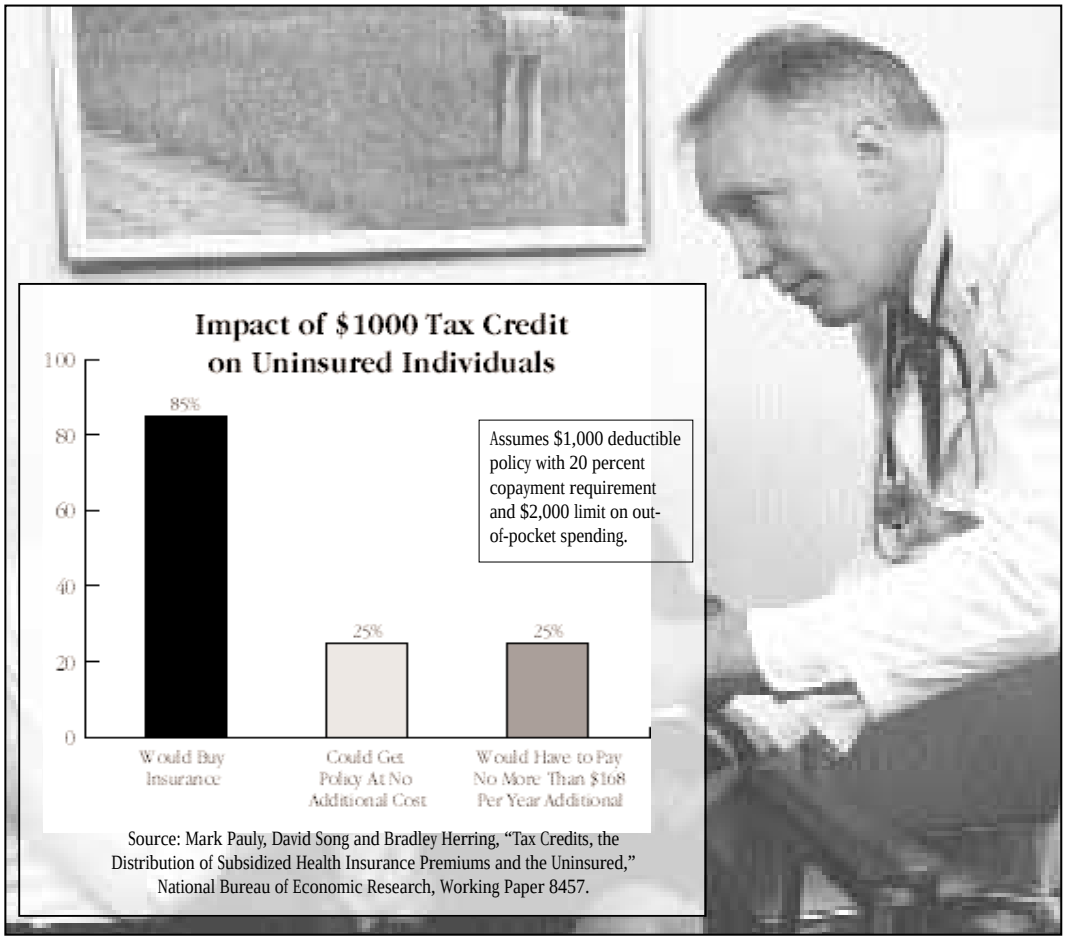
For more information…

WWW The scholarly study, "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured," written by economists Mark Pauly and David Song of the University of Pennsylvania and Bradley Herring of Yale University and published by the National Bureau of Economic Research (NBER), is available on the Internet at **http://www.nber.org/papers/w8457.** The political tract, "A 10-Foot Rope for a 40-Foot Hole," issued by FamiliesUSA, is available online at: **http://www.familiesusa.org.**



Source: Mark Pauly, David Song and Bradley Herring, "Tax Credits, the Distribution of Subsidized Health Insurance Premiums and the Uninsured," National Bureau of Economic Research, Working Paper 8457.

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State Legislative Update

COMPILED AND EDITED BY CONRAD F. MEIER

California

In a letter to state legislative leaders, Gov. Gray Davis (D) renewed his push for legislation to ensure continuity of care for patients when their doctors and managed care organizations have contract disputes.

Bills to ensure such coverage stalled in the last week of the legislative session in September. Davis said passage of such legislation is "imperative" to protect as many as 800,000 residents from "disruptions in their health care."

Under current law, only those patients in the final months of pregnancy or those who are being treated for "serious illnesses" such as cancer or AIDS may continue to see their doctor during contract disputes.

Florida

The state is weighing a new type of managed care plan, called an exclusive provider organization, or EPO. Florida's Medicaid program, which costs the state about $10 billion per year, currently requires beneficiaries to choose either a Medicaid managed care plan or traditional Medicaid, which is called Medipass in Florida.

State Rep. Frank Farkas (R), vice chair of the state House Health and Human Services Appropriations committee, said, "The Medipass model is very expensive. And there are some areas in the state where there are no Medicaid HMOs available, so patients have no choice but to enroll" [in Medipass].

Of the state's 1.8 million Medicaid beneficiaries, about 550,000 are enrolled in a managed care plan. To save costs and offer patients another managed care option, the state is considering an EPO, a less-restrictive option than an HMO. Under an EPO plan, Medicaid will cover care for beneficiaries only if it is provided by doctors within a network.

"This would be a good compromise," Farkas said. "We're trying to give Medicaid patients the ability to contract with doctors who might save [the state] money."

Iowa

The Iowa Department of Human Services' Council on Human Services, a policy-making board, has agreed to reconsider cutting 4,000 Medicaid recipients whose limited resources keep them just above the eligibility line for medical services.

Faced with eliminating $18.6 million in Medicaid spending to comply with 4.3 percent in cuts ordered by the state, the council had agreed to drop all 4,000 medically needy beneficiaries from Medicaid.

However, Lt. Gov. Sally Pedersen (D) has convinced the council to discuss the issue further. State Department of Human Services Director Jessie Rasmussen said eliminating the 4,000 beneficiaries could save the state between $8 million and $10 million.

If the council ultimately decides not to cut medically needy beneficiaries, members suggested cuts could be made to "a range" of Medicaid services or to care providers' reimbursement rates.

Massachusetts

Acting Gov. Jane Swift (R) vetoed $250 million from a state budget plan approved by the state legislature and released a $600 million supplemental budget request that would restore funding for Medicaid and mental health programs.

Faced with a $1.4 billion budget deficit, state lawmakers approved a $22.6 billion budget that would cut $650 million from earlier spending plans, including $22 million earmarked to place mentally disabled adults in group homes. The legislature's budget also would cut spending for AIDS treatment and prevention programs by $12 million, and reduce the Department of Mental Health's budget by $27 million.

Swift's vetoes included cutting a $17 million allocation to smoking cessation programs. Stephen Crosby, Swift's administration and finance secretary, said the governor decided the smoking prevention efforts are "less important" than funding "direct services," such as care for people with mental illnesses.

Minnesota

Faced with a "serious" economic situation because of declining tax revenues, Minnesota Finance Commissioner Pam Wheelock has "halted indefinitely" about $200 million in state grants to not-for-profits and nongovernmental organizations, including groups that provide health care services.

State agencies that contract with the organizations are uncertain how the funding freeze will affect them. At the Department of Human Services, for example, about 80 percent of its contracts are for programs mandated by the federal government that cannot be halted. However, money for other initiatives, such as substance abuse programs, could be withheld, according to Michael O'Keefe, commissioner of the Department of Human Services.

Missouri

The Missouri House Interim Committee on Nursing Home Caregiving recommended a plan that would reform the system the state uses to determine reimbursement rates nursing homes receive under Medicaid, which covers about 60 percent of the state's nursing home residents.

Under the present system, nursing homes receive daily, per-resident payments based on 1992 cost reports filed by the facilities, with "annual adjustments for inflation and other factors." The process has resulted in a "wide range" of rates.

The committee has recommended the state use more recent cost reports to update Medicaid reimbursement rates. Doing so could cost the state an additional $57 million to $132 million per year, according to a state audit.

State Rep. Sam Berkowitz (D), chair of the committee, said increased Medicaid reimbursement rates would improve the quality of care in nursing homes.

Although Missouri faces budget problems, the committee said the state could fund the proposal through use of the Medicaid loophole. Under the loophole, states pay city- or county-owned health care facilities more than the actual cost of health services, receive additional federal matching funds from the federal government, and require the facilities to return the additional state funds. Missouri is expected to draw at least $270 million this year through the loophole.

New York

The Empire State, which has long had among the most expensive Medicaid programs in the country, is leading the push in Washington, DC for still greater federal funding.

Gov. George Pataki (R) went to Washington to urge congressional leaders to include such a provision in the economic stimulus package. "The growing state budget shortfalls in nearly every state will continue to be a major drag on economic recovery," he said in a letter to Congress, adding, "I urge that the final economic stimulus package build upon the existing federal-state partnership by including a temporary increase" in federal Medicaid funding.

While the question of whether Congress will act to increase Medicaid funding remains up in the air, some struggling states have already begun to reduce benefits to deal with budget shortfalls. California, for example, has delayed expanding its CHIP program to adults until 2003. Other states, including New Jersey and Ohio, have considered using their shares of the national tobacco settlement to deal with costs.

Oregon

The right-to-die advocacy group the Hemlock Society has launched a campaign urging lawmakers to "override" Attorney General John Ashcroft's decision to pursue disciplinary action against doctors who prescribe lethal doses of drugs for terminally ill patients under Oregon's physician-assisted suicide law.

Under the law, doctors may provide, "but not administer, a lethal prescription to terminally ill patients who are Oregon residents." Two physicians must concur that the patient has "less than six months to live, has voluntarily chosen to die, and is able to make health-related decisions."

While an Oregon judge has temporarily blocked the order, the Hemlock Society is using newspaper advertisements and letters asking lawmakers to act or persuade President Bush to overturn Ashcroft's directive.

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How to Solve Texas' Uninsured Problem:

In October 1999, then-Governor George W. Bush appointed members to a Blue Ribbon Task Force on the Uninsured, created by the Texas Legislature to examine the problems of Texans who lack health insurance, to review demographic trends relating to the uninsured population, and to examine other state's programs, laws, and systems that address the lack of affordable health coverage.

Among those appointed by Bush was John C. Goodman, president of the National Center for Policy Analysis.

In a report issued in March 2001, the Task Force recommended expanding enrollment in the State's Medicaid program. Goodman disagreed, submitting the following minority report.

For more information…

WWW The full text of the report of the Blue Ribbon Task Force is available on the Texas Senate Web site at **http://www.senate.state.tx.us/75r/senate/commit/archive/BR/Blue_Ribbon.pdf.**

BY JOHN C. GOODMAN

The majority report of the BRTF was compiled by conscientious, well-intentioned people. However, we the undersigned believe the majority report has failed to identify the fundamental reasons why there are so many uninsured in Texas. Nor does the report explain why the number of uninsured in Texas continued to rise during a decade of rising incomes and unprecedented economic growth. Further, we believe that even if all the majority recommendations were fully implemented, the number of uninsured in Texas would continue to rise, indefinitely into the future.

The Effects of Federal Policies

Over the past decade, virtually every state in the nation has made a major effort to insure its uninsured. Collectively, these efforts have failed. Nationwide, the percent of the population that is uninsured is higher today than it was in 1990.

One reason why state action has been so ineffective is that the most important government policies affecting uninsurance are federal government policies, over which state governments have little, if any, control. Perversely, federal policies actually encourage many people to choose to be uninsured rather than insured.

Federal policies also have other perverse outcomes that affect the state of Texas. In many cases, federal policies encourage people to choose public insurance (e.g., Medicaid and S-CHIP) rather than private insurance. Federal law also effectively prevents personal and portable insurance. And it prevents Texas from using its health care dollars in a way that would maximize health care outcomes.

Federal Tax Law

The federal tax law encourages all Americans to obtain health insurance through an employer by excluding employer payments for health insurance from the employees' taxable income. For a middle-income family, this means that health insurance fringe benefits escape, say, a 28 percent income tax and a 15.3 percent (FICA) payroll tax. For these families, the government is effectively paying for 43 percent of the cost of the insurance.

The subsidy is much less generous for those who earn lower incomes. For example, almost half the work force pays no income tax. For these employees, the federal tax exclusion is worth only the 15.3 percent saving in forgone payroll taxes. The reason why firms that employ low-skilled workers are less likely to offer health insurance to their employees is that untaxed health insurance (relative to higher taxable wages) is less attractive for these employees.

Whatever the reason, approximately 81 percent of Texas' small employers do not offer health insurance to their employees, and if the employees purchase insurance on their own, they get virtually no tax relief. (See Figure I.) Thus for a large number of Texans, federal tax policy toward private insurance is one of indifference. There is no tax subsidy for those who insure; and no tax penalty for those who remain uninsured.

What is the alternative to having private insurance? People who do not qualify for public programs (e.g., Medicaid) must rely on their own resources and on charity care. As the majority report notes, Texas currently spends about $1,000 per year on free care for every uninsured person in the state, on the average. That implies that the value of "free" care is about $4,000 a year for a family of four.

Interestingly, $4,000 is an adequate sum to purchase private health insurance for a family in most Texas cities. Therefore, one way to look at the choice many Texas families face is: they can rely on $4,000 in free care (on the average) or they can purchase a $4,000 private insurance policy with after-tax income. Granted, the two alternatives are not exactly comparable. Families surely have more options if they have private insurance. But for many, the free care alternative will appear more attractive.

Federal Spending on Indigent Health Care

Although the federal government offers very little financial incentive for people to purchase their own insurance, it is a major source of funds for free care made available to the uninsured.

There are more than 40 federal programs that fund health services for the uninsured in Texas. The largest single program, spending more than $1.5 billion a year, is the disproportionate share hospital (DSH) payment program, designed to compensate hospitals that serve a larger than average number of indigent patients. Just over 60 percent of funds for the program in Texas come from the federal government. There are also programs for public housing residents, seasonal farm workers, legal immigrants, and even undocumented immigrants.

"[W]e believe that even if all the majority recommendations were fully implemented, the number of uninsured in Texas would continue to rise, indefinitely into the future."

Is there a way to redirect the money we now spend on free care in order to give people an incentive to be insured, rather than uninsured? For example, could Texas use some, or all, of its uncompensated care money and subsidize the purchase of private insurance for the families who currently rely on our indigent care system? Unfortunately, federal law makes this approach virtually impossible. In general, DSH money is money available only to offset unreimbursed hospital expenses. Other federal funding is similarly constrained.

Federal Subsidies for Public Health Insurance Programs

Approximately 1,781,000 Texans are insured under the state's Medicaid program, and 239,000 children are insured under S-CHIP. Although managed by the state, these programs are created under federal law, and the federal government provides the bulk of the funding (60 percent of Medicaid and 73 percent of S-CHIP).

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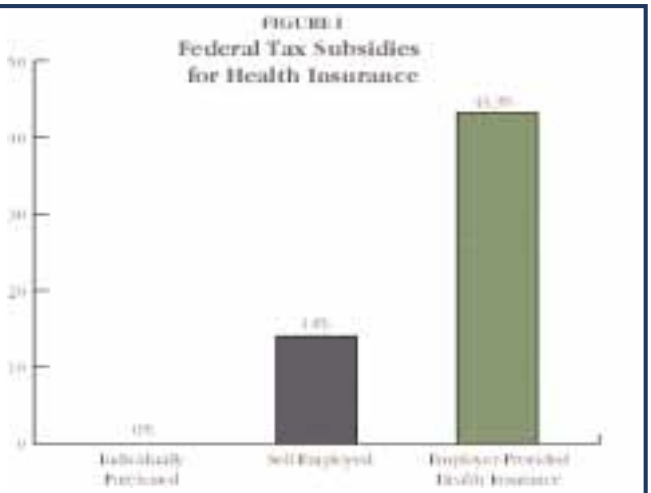
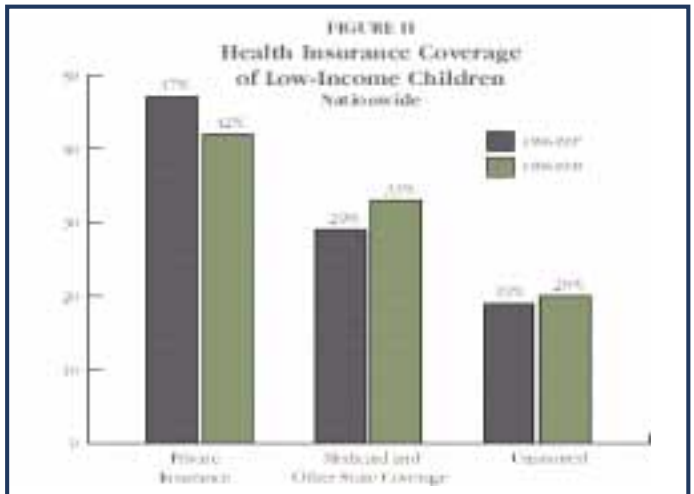
A Minority Report



Note: Assumes taxpayer is in 28% bracket. Individually purchased insurance is not tax-deductable. Self-employed workers can deduct 50% of cost of a policy (tax rate of 28% * 50% = 14 %). The employed workers save 28% federal income tax and 15.3% FICA on employer-sponsored health insurance (28% + 15% = 43.3%).



Note: 5% in 1996-1997 and 6% in 1998-1999 had other public coverage such as Indian Health Services. Source: Center for Studying Health System Change.

When Congress passed legislation creating Medicaid and S-CHIP, the clear intent was to provide insurance for those who would not otherwise be insured by the private sector. However, there is evidence that the expansion of these two programs is coming at the expense of private insurance. That is, people are dropping their private coverage in order to take advantage of their eligibility for public coverage. (See Figure II.)

It is not difficult to understand why. Families who obtain insurance coverage from an employer are benefiting from, say, a 15 percent (tax) subsidy; whereas families who qualify for public insurance enjoy a 100 percent (spending) subsidy. As a result, when people drop their private insurance and enroll in public programs, the cost to the taxpayer climbs from 15 percent to 100 percent. Thus taxpayers take on a major new burden, but little is accomplished in return.

Precisely because of the substitution of public for private coverage, the expansion of public programs is usually a very costly way to increase the number of people with insurance. For example, when Congress passed the S-CHIP program, the Congressional Budget Office (CBO) predicted large-scale substitution of public for private insurance. As a result, the CBO predicted that the cost of S-CHIP would be about $3,000 for each newly insured child, at a time when private insurance could be purchased for $500 or $600.

Under current federal law, there is not much the state can do to prevent this outcome. However, if the law were changed, states would be able to use their Medicaid and S-CHIP money to encourage private insurance instead. For example, rather than enrolling a child in S-CHIP, the same money (or some portion of it) might be used to pay the employee's share of the premium in a parent's employer-provided health plan. Such options would not only save money for the state, they would also be family friendly—allowing all members of the same family to enroll in the same health plan and see the same doctors and at the same facilities.

Federal Laws Preventing Portability

One of the disadvantages of our current system of employer-based health insurance is that employees must switch health plans every time they switch jobs. Even if they don't change jobs, once a year their employer can opt for a new health plan. And every change of health plans potentially means the employee will have to change doctors. As a result, it is a system under which there can be no continuity of care.

Another problem is that when health plans are selected by employers, they will tend to meet the needs of employers rather than the needs of individual employees. The result is health insurance that is less valued by employees and less attractive to them.

An alternative to this arrangement is a system of personal and portable insurance. Employers could still pay the premiums (as they do now) in order to take advantage of the federal tax subsidy. But the insurance could be owned by the employees and they could take their insurance with them as they move from job to job on their journey through the labor market. An example of such a system is a proposal developed by the National Center for Policy Analysis and Blue Cross/Blue Shield of Texas.

An obstacle to implementing such a system is the Health Insurance Portability and Accountability Act (HIPAA). Although advertised as enabling portability at the time of its passage, HIPAA in fact makes portability impossible. The reason is that HIPAA (combined with the provisions of ERISA) makes it impossible for employers to purchase individually owned insurance for their employees.

Federal Obstacles to the Efficient Use of Public Health Care Dollars

Texas communities receive health care funding both from the state and from the federal government. These funds flow through such programs as Medicaid, S-CHIP, DSH, etc. However, each of these programs has its own set of rules, narrowly prescribing how the funds may be spent. The result is that local communities have no power to allocate resources in ways that would maximize their impact.

For example, in one community the greatest return on health care spending may come from fluoridating the water supply. In another community, the greatest return may come from improving sanitation. Yet local communities have no authority to use their diverse health care funding to achieve these goals.

An example of a community that is adversely affected by such restrictions is El Paso. El Paso (upper Rio Grande) has low utilization of Medicaid per Medicaid-eligible person, but high spending for uncompensated care per uninsured person.

As a result, El Paso's low-income population overutilizes hospital care and underutilizes outpatient care. The city and its people would be better off if it were free to reallocate funds from inpatient to outpatient care. But restrictions on the use of funds apparently make this option difficult, if not impossible.

Ideally, cities like El Paso should be able to combine their funds for Medicaid, S-CHIP, and DSH and freely allocate those funds so as to achieve maximum health impact.

Recommendations

The Texas Legislature should by means of resolution call on the federal government to enact changes in policies that would:

- Allow the state of Texas to combine all federal and state health care dollars currently being spent on health care for low- and moderate-income families and allocate those funds without restriction so long as the money is spent on indigent health care.
- Allow the state of Texas to use funds now available through Medicaid, S-CHIP, DSH, and other programs to subsidize private insurance instead.
- Allow the state of Texas to give employers the opportunity to purchase individually owned, personal, and portable insurance for their employees without tax penalty.

The March issue of Health Care News *will present the conclusion of John Goodman's report, a proposal to create personal and portable insurance in Texas.*

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The *SimpleCare* Story

BY VERN S. CHEREWATENKO, MD, MED

Editor's note: In "Fee-for-Service Health Care Makes a Comeback," published in the inaugural (March 2001) issue of Health Care News, we offered a brief introduction to SimpleCare, and described how the program had grown to about 600 medical providers in 43 states. Here is the rest of the SimpleCare story, written by one of its founders.

I graduated from the University of Washington and am a board-certified Family Physician. I owned five family medicine-integrated medical clinics in the Seattle, Washington area, and as a consequence was very involved with all medical insurances—including Medicare, welfare, L&I, and several managed care contracts, in addition to a regular menu of insurance company patients.

My partner, David MacDonald, DO had recently joined me in practice. Dr. MacDonald is a highly respected board-certified Family Physician with an impeccable academic background.

"We were able to reverse our 'patient-to-paperwork ratio' from 1:7 (1 minute with the patient, 7 minutes on paperwork) to 7:1 (7 minutes with the patient and 1 on paperwork), resulting in increased quality time with the patient."

A physician-colleague had a similar family practice, with multiple health care providers in five clinics open 365 days a year.

Both of our groups were dedicated to providing comprehensive, integrated medical wellness care for our patients. We both were extremely busy, never at a loss for patients. We created and founded the largest IPA in Washington State, in an attempt to protect the practice of independent medicine and assure continuity of care for the Medicaid and Medicare patients we had served over the years.

What Were We Doing Wrong?

Needless to say, we created a monster.

The IPA was born out of our passion to "stay alive"—we wanted to stay in business. The IPA, however, began to eat us alive instead!

On a Sunday morning about 18 months ago, Dr. MacDonald and I sat down to figure out why, when we couldn't be busier, were we losing so much money? Why were we rapidly flying our businesses straight into the ground…not to mention the usual "where has the fun gone" stuff.

We both had excellent business staffs and business-wise ran a very tight ship. Our combined practice billings totaled over $10 million—not a tiny operation by anyone's definition. Yet we calculated we were losing approximately $7 per patient, or $80,000 per month.

That loss could not be made up in volume. The standard managed care response—"You just need more patients to win at the capitation game"—couldn't have been farther from the truth! Believe me . . . we tried. Between the two clinic systems we took care of approximately 75,000 patients a year with 55 providers between us. The losses continued, and we depleted our total net worth and assets over a two-year period.

We knew we were losing money on several insurance types—Medicare, welfare, L&I, Pacific Care, Aetna, NylCare—virtually every managed care plan. We feared we could not suddenly cancel all managed care contracts . . . but the reality was we couldn't remain viable if we continued with them.

The Paper Chase

Our practice was literally being exterminated by an expanding amount of paperwork intended to "improve care and hold down costs." At one time we needed six medical records clerks, up from two, just to photocopy the records of patients who, on a monthly basis, transferred in and out of our care on these various managed care plans.

We took a look at an average patient charge:

- My charge for a 10-minute patient visit was $79.
- The insurance companies typically reimbursed $43.
- Costs of collection were anywhere from $5 to $20 depending on the staff time, billing system, etc. All doctors know they don't get reimbursed the full amount they charge for a visit, but most doctors completely overlook what it costs to collect even the discounted reimbursement.

By our calculation, then, I was actually being reimbursed $23 for a $79 office visit charge! Add in the overhead for the exam room (the national average is $30), and we discovered we were losing about $7 on each of the 75,000 patients we were seeing annually!

We could not cut our overhead any further—we had been doing that for the past two years (cheaper photocopy paper, less-fancy patient info, fewer nurses, fewer receptionists, no more "pantry stocking," and so on). We were running as lean as we could . . . practically on bare bones.

"Cash Only" Solution

In April 1998, we looked again at the $80,000-a-month loss, concluding we both were destined to be bankrupt in six months.

Looking around the country to see if we were alone in our struggle, we were alarmed to find doctors everywhere were beginning to file bankruptcy in increasing numbers.

We concluded that a new system was the only way we and many of our colleagues could possibly survive.

"SimpleCare is a 'different animal'—no insurance billing, no extensive 'document for the insurance company chart notes.'"

As we searched for solutions, it quickly became apparent that if people would pay us for our services today, at the time of service, we could immediately cut fees in half . . . and begin to get out of those ridiculous insurance contracts. They were either bad because they didn't pay enough, bad because they created too much paperwork and bureaucracy, or bad because they set us up for a fraud/felony charge when "examining parties" didn't agree with the way we coded something.

We re-explored the "cash only" concept by asking ourselves, "How many health consumers in the U.S. represent the 'cash-paying' public?" The answer? Nearly 50 million Americans (1/5th of the country) are uninsured, and most would be very willing to pay a reasonable fee for their care, if they could find doctors who would accept payment in full at the time of service.

Trust me on this—we've been doing it and our patients are delighted!

SimpleCare Is Born

It was with great pride that we founded "SimpleCare":

- 100 percent patient-focused care
- No lists of who can and can't see us
- No lists of what patients can and cannot have
- No confusing and changing CPT codes
- No insurance or patient billing
- 100 percent bureaucracy-free
- Hassle-free medicine!

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For more information…

WWW visit the AAPP Web site at **http://www.aapp.net,** and the SimpleCare site at **http://www.simplecare.com.** You can also email your questions to membership@simplecare.com. Doctors and health care practitioners can join the AAPP for just $35/year; membership gives you the SimpleCare plan and other benefits. Patients can join the AAPP for $20/year (individual) or $35/year (family).

SimpleCare is a "different animal"—no insurance billing, no extensive "document for the insurance company" chart notes. Just real medicine, real time with patients, real money paid before the patient leaves the office, and patients charged based on a simple coding system: Short, Medium, or Long.

We're also working to establish a nonprofit organization, the American Association of Patients and Providers (AAPP), representing patients and providers of health care who want to work together to fix the health care system. Rather than insurers, attorneys, and special-interest groups, why not patients and doctors as the agents of change?

Our nonprofit application is pending, but the organization is up and running. The membership fee is between $20 and $35 a year—inexpensive, because we want to attract a large activist membership quickly.

Common-Sense Coding

We developed SimpleCare from a clean slate, creating a common-sense, no-hassle system for seeing patients and getting reimbursed fairly, without penalizing patients who pay for their visit before leaving the office—just as they do for the vast majority of goods and services they buy.

We created a simple coding system: just three codes rather than the 7,500 +/- codes found in the CPT manual. The CPT scheme was designed for billing; since we weren't billing anyone, we didn't need (and didn't want) to use the overly complex CPT scheme. One physician asked, "But is this legal?" I can't tell you how many doctors think the CPT manual is a legal document; it's not. It is nothing more than a joint venture between the American Medical Association and the Health Care Financing Administration (now the Centers for Medicare and Medicaid), for coding uniformity only.

Our three SimpleCare codes are S-M-L: 10 minutes is an S (Short); 20 minutes is an M (Medium); and 30 minutes is an L (Long). Our clinic charges $35 for an S, $65 for an M, and $95 for an L. A reasonable fee—without the paperwork costs—is assigned to specific procedures, lab work, x-rays, etc.

Other doctors across the country have employed SimpleCare and have adopted the S-M-L system using their own fee structures. We do not tell doctors what to charge for their respective S-M-L or procedures. Individual doctors set their own fees and agree to take the SimpleCare Pledge:

"I will give my patients, that pay in full at time of service, my best price."

Highly Satisfied

We've developed a few SimpleCare office forms, but we're no longer burdened by thousands of dollars for administrative hardware, software, staff time, down time, re-bill time, fight time, denial time, etc. Because we aren't burdened by these costs, our patients aren't either. It would be completely unethical, of course, to charge patients for CPT-related billing services that aren't being used because patients are paying in full at the time of service.

We even saved the $49 it would have cost us for a new CPT book and determined SimpleCare was immediately Y2K-compliant. Within three months, we went from losing $80,000 a month to making $10,000 a month. According to AAPP estimates, if the entire U.S. health care system were converted to SimpleCare, American patients would eventually save some $300 billion annually!

The cash-paying patients love SimpleCare: There's less wait before seeing the doctor, and they no longer have to pay exorbitant fees pushed up by excessive administrative costs. We were able to reverse our "patient-to-paperwork ratio" from 1:7 (1 minute with the patient, 7 minutes on paperwork) to 7:1 (7 minutes with the patient and 1 on paperwork).

Our patients receive more quality time from their physicians, and there has been a quantum drop in complaints from our patients as we have rid ourselves of the "busy work" of managed care. The office runs more efficiently and "clinic stress" fell immediately. The nurses are ecstatic; they no longer have a phone attached to their ears, listening to "hold" music for 45 minutes as they plow through bureaucracies. They are back to referring patients to the specialists we, or the patients themselves, choose . . . and it now takes 30 seconds, rather than 45 minutes, for the referral to take place.

Regaining Control

We knew the SimpleCare system was allowing us to regain control of our destiny. We knew we were doing absolutely the right thing for our patients and for health care in general.

With that confidence, we were able to take the next step to free ourselves from the red-tape laden health care system. With staff input, we identified the insurance companies that were the greatest source of frustration for us: low reimbursements, delayed reimbursements, and/or excessively burdensome paperwork. We began to send the problem companies 90-day cancellation notices. We were able to phase out the "bad apples" and phase in a new population of cash-paying patients. There's a lot of them out there.

News about this simple, fair form of health care is spreading. Over the last year articles about SimpleCare have appeared in the *Wall Street Journal*, *Puget Sound Business Journal*, *South County Journal*, and *Medical Marketing News*. Dr. MacDonald and I have told the SimpleCare story to national radio talk show audiences from New York to Washington—including National Public Radio, the HealthMax Health Hour, and the Medicine Man Show. We've gained the attention of several state medical associations, the Association of American Physicians and Surgeons, and many small and large businesses. Dr. MacDonald and I have been giving seminars to many community organizations, all with very positive ("It's about time!") responses.

A Call to Action

SimpleCare is not theoretical, "chalk-board" talk. We've tested the program and continue to expand it daily in clinical practice …and in the process have managed to save a small family medical practice in Renton, Washington from becoming extinct. SimpleCare has given us the power to rid ourselves of the red tape burden imposed by more than a dozen insurance companies, with more on the chopping block. It's allowed us to get back to the business at hand: caring for our patients, rather than caring for their insurance companies. We are getting paid a fair price for our services and spending much more quality and productive time with our patients.

"[SimpleCare has] allowed us to get back to the business at hand: caring for our patients, rather than caring for their insurance companies."

If you sincerely and passionately wish, as I did, to regain control of

- your professional career,
- your patients,
- your life,
- your practice,
- your income, and
- your ability to practice unencumbered medicine,

then SimpleCare is that solution.

We now have nationally licensed clinical laboratories ready to go, with pharmacies and radiology groups joining in. Many people with whom we have discussed SimpleCare feel it is the quickest, simplest, most ethical, and most common-sense approach currently on the table to fix the uninsured, under-insured, and poorly insured (high cost-low value) problem in this country. That is precisely why we are escalating the national expansion of this plan.

I welcome you to be part of the solution!

Vern S. Cherewatenko, MD, M.Ed. is chairman, president & CEO of the American Association of Patients and Providers. He can be reached by email at drvern@aapp.net.

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State Risk Pools Under the Gun

See related story on page 14.

RISK POOLS continued from page 1

The board of directors of the National Association of State Comprehensive Health Insurance Plans (NASCHIP) recently distanced itself from the report. "The NASCHIP board of directors did not participate in the drafting of the Commonwealth study, nor does it concur with the opinions expressed by the authors, nor does it believe its conclusions are borne out by the facts."

The rest of this article quotes the study's major findings, followed by rebuttals based on the comments of risk pool program officials contacted by the author.

Rebuttals

- The Executive Summary of the report claims "Some pools have long waiting lists, and some are closed to new applicants all together."

In fact, 25 operating state programs are open year-around and are accepting new enrollees. Only one is closed, and it has been for 10 years. Only two, California and Louisiana, currently have waiting lists for new enrollees as they wait for their legislatures to provide additional funding or make other changes. Illinois recently had a waiting list for a short period of time, but no longer does. It is absolutely wrong to imply that state risk pools commonly have waiting lists or are closed.

- In a news released dated August 10, 2001, Commonwealth claimed "... the existence of these pools are [sic] rarely publicized."

Nearly all states with risk pools require insurance carriers, when they deny an individual coverage, to inform that individual about the existence of the state pool and his/her ability to get coverage there. All pools and state insurance departments provide information to agents and brokers as part of ongoing informational efforts. Pools have done public service announcements and public information programs.

- The report claims "Many of the programs have high deductibles and co-payments ... and often restrict annual and lifetime benefits."

That is a very deceptive statement. Virtually all of the risk pools provide comprehensive major medical benefits and plans comparable to what is widely viewed as regular quality coverage in the individual market. 80/20 coverage (20 percent co-pay, sometimes more if out of network) is the norm for nearly all risk pools, and it's the norm for individual market coverage.

Every risk pool offers a deductible of $1,000 or less, and 19 offer deductible options of $500 or less. Many of the pools also offer higher deductible plans. At one point, the study notes deductibles range up to $10,000, and out-of-pocket stop loss limits are $2,000 to $2,500 (again normal) but can range as high as $10,000.

Alaska's HIP has a $10,000 deductible option. But it also offers $500, $1,000, $1,500, $2,500, and $5,000 deductible options. Alaska also has a $10,000 stop loss limit—but only on the $10,000 deductible plan, which means all costs are covered after that deductible.

On December 31, 2000, the Alaska HIP had 395 policy holders. Of those, 31 had the $500 deductible, while 25 had the $10,000. It's clear the Commonwealth report's authors did not paint a full, accurate picture.

- The report says state risk pools "often restrict annual and lifetime benefits."

In fact, 20 of the state HIPs offer lifetime maximum benefits of $1 million or more. Once again, $1 million lifetime maximums are normal. In a couple of instances there is no limit, but that is rare in the individual market. Some of the HIPs are at $2 million, and one is at $1.5 million. Six have $500,000 lifetime maximum benefits.

One state, Wyoming, offers a plan with a $350,000 lifetime maximum, adopted to protect the small state and risk pool from the impact of one major hit. But Wyoming also offers another plan with a $600,000 lifetime maximum.

At a roundtable discussion among state pool directors attending the October 5, 2001 NASCHIP annual meeting in Omaha, Nebraska, the representatives were asked if they knew how many individuals had hit their lifetime maximums over the life of their programs. Of the 17 states represented at that particular session, the group collectively identified 18 individuals who had hit their lifetime maximums. The risk pool officials represented plans that, in some cases, had been existence for nearly 25 years.

Several of the pool directors at the meeting noted some individuals (also a small number) come from the group market to the pools because they've max'ed out on the lifetime benefits in their employer group. Lifetime maximums are common in health insurance, and the fact state HIPs have lifetime maximums is hardly a fair criticism.

- The authors claim, "High-risk pools often require waiting periods for people with pre-existing conditions, despite the fact that they were designed to help individuals with serious or chronic illness obtain health insurance."

For people coming into the programs uninsured, all high-risk pools have waiting periods for pre-existing conditions. This is normal practice for the individual health insurance market. For individuals previously insured under other health plans, nearly all of the pools apply creditable coverage.

"25 operating state programs are open year-around and are accepting new enrollees. Only one is closed, and it has been for 10 years. Only two, California and Louisiana, currently have waiting lists for new enrollees ..."

Waiting periods for coverage of a pre-existing condition treated in recent months (but no waiting period for coverage of other health care services) are a normal part of individual health insurance. Even New York, a guaranteed-issue state with many mandates and regulations, has a 12-month waiting period with a six-month look back for pre-existing conditions.

It is simply wrong for the authors to imply that by having waiting periods for pre-existing conditions risk pools provide poorer-than-normal coverage.

- The report faults state risk pools for charging premiums that are high relative to incomes.

There is some truth, but also many mischaracterizations and omissions, in the Commonwealth report's conclusions on this issue.

The authors estimated average premium costs for a select group of risk pools and compared those averages to median household income. It is difficult to judge the accuracy of the average estimates, since the report's authors don't explain in detail how they arrived at them. State risk pools charge a wide range of premiums, varying from state to state and by age, geographic area, and the details of the plans offered.

RISK POOLS continued on next page

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RISK POOLS continued from previous page

At no point did the study compare risk pool premiums with comparable coverage in the individual market—certainly a more apples-to-apples comparison of how risk pool costs vary from what would otherwise be available in the commercial market. And no comparison was made with individual market coverage in the guaranteed-issue states. Several risk pools, serving even their small populations, have lower rates than what everyone, healthy or not, is charged for some guaranteed-issue plans.

The Commonwealth study found that the overall average premium among the sample risk pools was $3,083. By comparison, the Kaiser Family Foundation recently released the results of a survey that found employer-sponsored group insurance costs have gone up and average $2,652 for individuals ($7,056 for families). And that's for group coverage, normally significantly less expensive than individual coverage. That suggests risk pool coverage is not all that expensive.

"The misleading report ... often uses selective information about one or two state programs to paint negative conclusions about the state risk pool system as a whole."

It is true, however, that risk pool premiums vary significantly from state to state, depending upon how the legislatures, boards of directors, and other policy makers designed the program. Some pools are comparatively affordable, and those do generate more enrollment than pools that are more expensive. That's what policymakers do: Make choices, balancing costs against benefits.

- The report chastises risk pools because "enrollment rates are extremely low."

It's important to remember that risk pools are not designed or intended to solve the uninsured problem. That is widely and accurately seen as a socio-economic issue, not an insurance issue. Risk pools are first and foremost designed to address access, in a particular market segment of the health insurance industry where the problem is inherently more acute.

The report estimated that risk pool total enrollment amounted to about 1.2 percent on average of the individual market in the states with risk pools, based on estimates that the individual market serves about 7 percent of the overall national population under age 65.

State risk pools in Minnesota, at 6 percent, and Nebraska, at 3 percent, had the highest percentage of individual market enrollment. The rest were under 2 percent.

The fact is, the number of potential enrollees in state high-risk pools simply *is* a small number. Estimates of the number of risk pool-eligible people in any state or the country are extremely speculative. A study of Minnesota's large and relatively affordable state risk pool (currently serving 26,000+ individuals) concluded it had served in the neighborhood of 250,000 people at one time or another since it started operation in 1977.

It's commonly thought that perhaps 1 percent of the overall insurance market would be considered "uninsurable," or denied health insurance due to a preexisting condition. But little reliable research underpins that or any other such estimate.

For more information…

WWW The full text of Bruce Abbe's "Response to the Commonwealth Study on Risk Pools: State Health Insurance Pools for the High-Risk Population - 25 Years of Proven Service in Guaranteeing Access to Coverage" is available free of charge through *PolicyBot*, The Heartland Institute's online research service. Point your Web browser to **www.heartland.org**, click on the PolicyBot icon, and search for document **#3236702.**

The full text of the Commonwealth Study is also available through *PolicyBot,* document **#3236701.**

The term "uninsurable," in fact, is considered a misnomer in many risk pool circles. Everyone is insurable, they argue; it's just a matter of developing a way to insure them that does more good than harm. That's what risk pools are all about.

Risk pools are *designed* to serve a small portion of the market; that's their purpose.

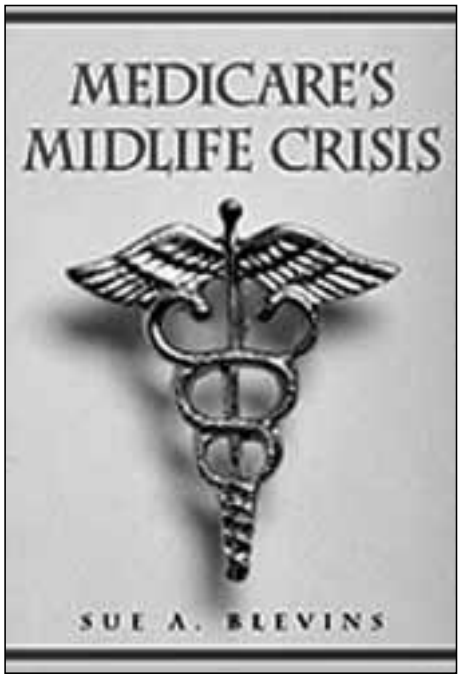
Conclusion

If you read the Commonwealth report and came away with the impression that all risk pools are too costly, have poor benefits, and are frequently closed for new enrollment, it's understandable that you did. That's what the authors wanted you to think.

But a closer look at the facts shows those conclusions are just not so.

Bruce Abbe, vice president of public affairs for Communicating for Agriculture, is editor of CA's annual directory on risk pools. He is also a member of the board of directors of the National Association of State Comprehensive Health Insurance Plans. He is based at CA's public affairs office in Bloomington, Minnesota.

MEDICARE'S MIDLIFE CRISIS



Most Americans, and even most seniors, know little or nothing about Medicare and the efforts being made to reform it. In this new book from the Cato Institute, Sue A. Blevins examines the program's origins, evolution, and future policy options. She recounts how Medicare was created as a part of a larger plan for universal health insurance. She finds that Medicare restricts health care choices, jeopardizes the doctor-patient relationship, and threatens to invade the medical privacy of seniors.

We won't regain control over our health care until we learn the lessons revealed through an examination of Medicare's history and consider the steps Blevins recommends for dealing with Medicare today.

"Sue Blevins painstakingly documents not just the dry legislative history but also the backroom political maneuvering that resulted in the Medicare program we have today. Her most disturbing revelation is of new evidence suggesting that government officials misled the public regarding the true cost of the Medicare program in order to gain its enactment. Anyone involved in the effort to reform the Medicare program should read this book and heed its lessons from the past."

Roland E. (Guy) King
Former Chief Actuary
Health Care Financing Administration

Cato Institute - November 2001 - $8.95 paper - $16.95 cloth - www.cato.org

BY SUE A. BLEVINS

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High-Risk Pools: A Primer

"The development of a high-risk pool is the best way a state can ensure that individuals suffering from catastrophic medical conditions have access to high-quality, affordable private health insurance coverage, while still preserving the viability and competitiveness of the state's traditional individual health insurance market."

BY JANET STOKES TRAUTWEIN

High-risk pools play an important role in the health care system. They are state-created, nonprofit associations that offer comprehensive health insurance benefits to individuals with pre-existing health problems.

People who typically seek coverage in a high-risk pool are those who have been turned down for coverage in the private market due to a chronic illness or condition; those who have found they can access only restricted coverage due to their health; or those who have coverage that costs more than what is available from the pool.

Insuring the Uninsurable

Risk-pool insurance typically costs more than standard coverage. Premiums are capped by law and range from 125 percent to 200 percent of the premiums charged for standard coverage.

It is inherent in the design of a risk pool that it will lose money. It simply isn't feasible to pool a group of individuals known to have major health problems and expect their premium contributions to cover the entire cost. For this reason, risk pools need some form of subsidy, often an assessment charged to insurance carriers in the state.

Risk pools are overseen by an appointed board of directors, usually including representatives from the insurance industry, consumers, and medical professionals. The pools are often supervised by the state's insurance department. A private third-party administrator typically handles day-to-day claims and administrative operations.

Overall enrollment in risk pools is rising. Today, approximately 127,406 people are enrolled in 30 state pools. Some of the enrollment increase can be attributed to federal HIPAA implementation passed in 1996, which allowed states to choose their risk pools as a mechanism to provide portability guarantees for people leaving qualified group coverage for the individual health insurance market.

People who enroll in high-risk pools are more likely to enroll due to access issues rather than financial considerations. They tend to be the self-employed, employees of small businesses that don't offer insurance, or workers who are not eligible for employer-sponsored coverage. For many, the risk pool functions as an interim solution until they become eligible for coverage elsewhere. On average, an individual spends 30 months in a state risk pool.

Stabilizing the Free Market

Risk pools are an important mechanism for providing stability in the individual health insurance market.

A pool provides a place where high-risk individuals can gain comprehensive coverage along with protection against premiums climbing too high. Pools give the insurance industry and the general public a way to share and spread out the costs of insuring medically risky people on a broad and predictable basis.

Recent studies of the individual insurance market, including studies by the Urban Institute in Washington, DC, have found that states with risk pools have had more success in keeping their individual health insurance markets competitive, keeping insurance rates affordable, reducing Medicaid enrollments, and increasing private coverage.

For more information…

WWW see *Heartland Policy Study* #91, "Extending Affordable Health Insurance to the Uninsurable," by Conrad F. Meier. The report is available on the Internet at **http://www.heartland.org/studies/meier-ps.htm**, or in Adobe Acrobat's PDF format at **http://www.heartland.org/studies/meier-ps.pdf.**

The development of a high-risk pool is the best way a state can ensure that individuals suffering from catastrophic medical conditions have access to high-quality, affordable private health insurance coverage, while still preserving the viability and competitiveness of the state's traditional individual health insurance market.

Best Practices for a Successful Pool

- Losses in excess of premiums should be funded equitably by all insurance carriers in the state, including re-insurers. This can be done through a proportionate assessment or through a per-policy (or per-employee in the case of group insurance or re-insurance) charge to all policyholders in the state.
- Pools should not rely on state appropriations, including those required due to premium tax offsets for carrier assessments, or the use of tobacco-designated funds. A reliance on such resources has been problematic in some states, since pool funding is then contingent on state revenues and the whims of the legislature. Several states funded in this manner have had to close pool enrollment for a time due to funding shortfalls.

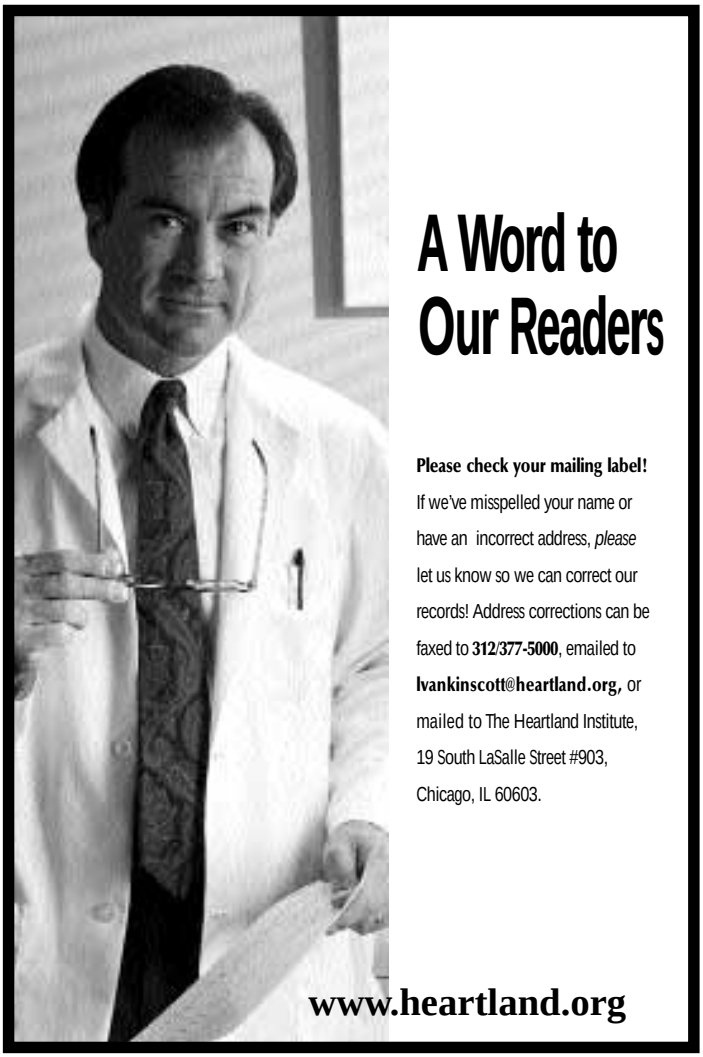
> **"Risk pools are an important mechanism for providing stability in the individual health insurance market."**

- High-risk pool premiums should average between 100 and 150 percent of the average market rate, and should be capped at no more than 200 percent. While it is fair for the uninsurable population to pay slightly more for private coverage, premiums should not be so high as to limit access for low- and middle-income families.
- Plan premiums should include an insurance agent referral fee, which is typically between $25 and $100 per case.
- The risk pool board should have industry representation, including insurance agents, as well as consumers and provider groups. A private third-party administrator should handle the pool's day-to-day operations, and it should be subject to oversight by the state Department of Insurance.
- The pool, like other traditional insurance options, should have an adequate lifetime maximum benefit limit (e.g., $1 million), and offer several plan options for participants (e.g., $500, $1,000, and $2,500 deductibles).
- For non-HIPAA-eligibles, the pool should have a pre-existing condition waiting period of at least six months to prevent adverse selection.

Pool eligibility for non-HIPAA-eligibles should be limited to individuals who have lived in the state for at least 30 days and can prove they meet at least one of the following conditions:

1. They have been rejected for individual coverage by at least one insurer (some states require proof of two rejections).
2. They have a catastrophic medical condition that allows for automatic pool acceptance without a prior carrier rejection (e.g., cancer, transplant cases).
3. They are presently insured but paying a premium higher than the premium available through the high-risk pool.
4. They are the dependent of an eligible individual.
5. They are HIPAA-eligible.

Janet Stokes Trautwein is director of federal policy analysis and state government affairs for the National Association of Health Underwriters. Trautwein monitors all health care bills and helps develop NAHU policy. She is the association's chief spokesperson. For 17 years, she ran an insurance agency in Austin, Texas, giving her a perspective on health insurance that few others on Capitol Hill have. Her email address is jtrautwein@nahu.org.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"Patient Safety" Initiative Could Lead to Rationing

BY CONRAD F. MEIER

The federal government's release of $50 million in patient safety grants may be used to create a national patient information system, warns the Citizens' Council on Health Care (CCHC), a Minnesota-based independent health care policy organization.

The U.S. Department of Health and Human Services (HHS) released the grants late in November, 2001.

According to Twila Brase RN, president of CCHC, "Thirty million dollars will be directed into 46 projects focused on improved data collection, use of computers, and information technology.

Dollars and Strings

Brase points to two specific examples of HHS access to individually identifiable patient data: the OASIS home health data collection system and the recently released federal medical privacy rule.

The federal Outcomes and Assessment Information System (OASIS), launched in 1999, collects—without patient consent—approximately 95 items of data on all adults receiving medical care other than maternity care. Home health agencies are required to submit the data to qualify for reimbursement from Medicare and Medicaid.

The privacy rule, released in April 2001 and set for implementation in April 2003, requires doctors, hospitals, and health plans to open their medical records on any day at any hour to HHS without patient consent or a search warrant. In addition, the regulation permits disclosure of data to medical and policy researchers, public health officials, law enforcement officers, and other persons and agencies without patient consent or a search warrant.

> **"The way to improve patient safety and reduce medical error, according to Brase, is to start eliminating corporate- and government-managed care and put patients and professionals back in charge of health care."**

According to Brase, "We are particularly concerned that a national health information system may eventually lead to federal control of the nation's entire health care system and its health care professionals. Electronic oversight could be a mighty tool in the arsenal of federal officials interested in rationing health care services. Regardless of a patient's need for care, fearful doctors may be unwilling to move forward without federal approval."

Medical Errors Overstated

Brase agrees medical errors do occur, but says there is disagreement on the definition of medical error and the extent of errors occurring. She cites recent studies from the Indianapolis-based Regenstrief Institution (1999) and researchers in the Department of Veterans Affairs (2000) that challenged the findings of the highly publicized studies done by the Institute of Medicine. The 1999 IOM studies claimed 44,000 to 98,000 deaths per year.

Research led by Rodney A. Hayword of the Veterans Affairs Center for Practice Management and Outcomes Research, reported in the July 25, 2001 issue of the *Journal of the American Medical Association*, confirms Brase's skepticism regarding the significance of the medical error problem. Hayword and his colleagues calculated the number of deaths due to medical error between 5,000 and 15,000 a year.

For more information…

WWW visit the Web site of the Citizens' Council on Health Care (CCHC), a nonprofit 501(c)(3) independent national health care policy organization based in St. Paul, Minnesota. **http://www.cchconline.org**

(See "New Study Says Medical Errors Are Overstated," *Health Care News*, September 2001.)

Basic Problems

Brase, a registered nurse, also thinks it does not require millions of dollars, scores of researchers, or comprehensive national databases to understand some of the underlying causes of medical error. Brase puts the blame on managed care tactics and the reimbursement schemes of HMOs and government programs.

"Patient quotas," says Brase, "along with long waits for referrals, change of doctors, drug formularies, loss of the patient-doctor relationship, gag rules, low professional morale, prior authorization delays, increased paperwork, poor reimbursement rates, market consolidation, use of non-medical staff, and inadequate hospital staffing have led to many of these human errors."

The way to improve patient safety and reduce medical error, according to Brase, is to start eliminating corporate- and government-managed care and put patients and professionals back in charge of health care.

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THE GALEN REPORT

A monthly review of health policy matters

Supporters of free-market health reform have a new reason to be in high spirits.

For nearly a decade, the health care debate has been dominated by proposals to expand government control over the health sector in any number of ways—expanding Medicaid, letting more people into Medicare, creating new programs like SCHIP, and regulating the socks off private health insurance.

But the tide may be shifting.

The debate in Congress over the best way to provide health insurance coverage for displaced workers signals the beginning of a new phase in which market-based policy initiatives are gaining strength.

The economic stimulus plan passed by the House contained a refundable tax credit worth 60 percent of the cost of an insurance policy (with no caps). Ways and Means Chairman Bill Thomas led the charge by putting his tax credit initiative on the table, and President George W. Bush followed with a complementary proposal of his own. While the Senate didn't act on the stimulus bill before the 2001 holiday break, passage in the House is a significant step forward.

"The debate in Congress over the best way to provide health insurance for displaced workers signals the beginning of a new phase in which market-based policy initiatives are gaining strength."

Equally important, free-market advocates now realize they have a winning hand with an idea on health care reform. House Speaker Dennis Hastert issued a fact sheet, saying that under the plan "developed by House Republicans and Senate Democrat Centrists, ANYONE eligible for unemployment insurance after losing their job would receive a health care tax credit to pay for their health care needs."

They claimed the egalitarian high ground with a tax credit idea that would reach not just those eligible for COBRA, but also the other "45 percent of laid-off workers in small and medium-sized businesses and those who never had job-based health care."

This signals an important opportunity to begin a new conversation on the best way to help people get health insurance. Giving individuals more control over their health spending through direct subsidies for private health insurance is the right answer for the uninsured, and also for Medicaid recipients and Medicare beneficiaries. Tax credits could create new energy for important consumer-driven changes in the health sector.

- Grace-Marie Turner

RECENT PUBLICATIONS

A Stubborn Fight Revived

Robin Toner
The New York Times, 12/20/01

The deadlock over the economic stimulus bill has shown that the debate over health care is very much alive. "It's the issue that won't go away, and the economy brings it four-square back to the front of the political agenda," says Diane Rowland, executive vice president with the Kaiser Family Foundation.

"Republicans want to use tax credits to help individuals buy insurance in the open marketplace," writes Robin Toner in *The New York Times*, and "Democrats want to shore up the employer-based system with federal assistance." Both sides are well aware that any changes made now will have an impact on future legislation.

http://www.nytimes.com/2001/12/20/politics/20ASSE.html
(free but requires registration)

How to Improve the Federal Employees Health Benefits Program

Chris Middleton
Pacific Research Institute, Action Alert

The Federal Employees Health Benefits Program (FEHBP) is being threatened by rising premiums and a decline in the number of available plans, says Chris Middleton of the Pacific Research Institute. Middleton argues the plan is being hurt by defined benefits that all plans are mandated to include and a "premium support" model that does not reward those who choose lower-cost health plans.

Three changes are recommended: 1) Repeal the 75 percent limitation (the percent the government will pay for each employee's plan) to "inject renewed price competition into the program." 2) Allow any new plan to participate—not just HMOs. 3) Eliminate mandated benefits, "allowing federal employees to choose the benefits package that they find to be the best value."

http://www.pacificresearch.org/pub/act/2001/act_01-12-12.html

Employers Report Significant Health Care Concerns and Are Looking for New Solutions

Hewitt Associates, LLC

A new survey by Hewitt Associates LLC finds "the rate at which health care costs are rising is alarming for employers," and they are looking toward models that expand consumer choice solutions. Hewitt surveyed more than 700 U.S. organizations and found health costs are "becoming a number one priority because they're impacting the bottom line."

Two-thirds say they are offering employees the ability to select from various levels of coverage and services at varied costs. Many are using tiered coverage not just for prescription drugs but also for hospital services. Others are giving employees new ways to comparison-shop online for coverage and services.

The key is increasing employee involvement in decisions by increasing their price awareness, although a big 39 percent said they "are not comfortable with consumers getting more involved" in health care decisions.

http://was.hewitt.com/hewitt/resource/newsroom/pressrel/2001/12-17-01.htm

Big Pharmaceuticals Take the Gloves Off

Stephen Pollard, Centre for the New Europe
The Wall Street Journal Europe, 12/17/01

Pharmaceutical companies have thrown down the gauntlet, "making it clear they've had enough of Europe's price-fixing ways," writes Pollard. Pfizer CEO Hank McKinnell and AstraZeneca CEO Tom McKillop are among those who say patients are being denied access to the best new medicines for years as a result of long negotiation with European governments over drug approval and prices.

Europe is refusing to "pay its fair share" and as a result, "the U.S. ends up funding all the research and development," says Steve Slovick with Cambridge Pharma Consultancy in New York. The consequences for Europe: cutting profits, which means cutting research, which means cutting back on innovation, which means cutting the number of patients who can be helped.

http://www.wsj.com

The Galen Report is a monthly review of health policy matters provided by the Galen Institute, P.O. Box 19080, Alexandria, VA, 22320, www.galen.org. Grace-Marie Turner is president. The report is compiled by editor Elizabeth Lamirand, who can be reached at 703/299-9550.

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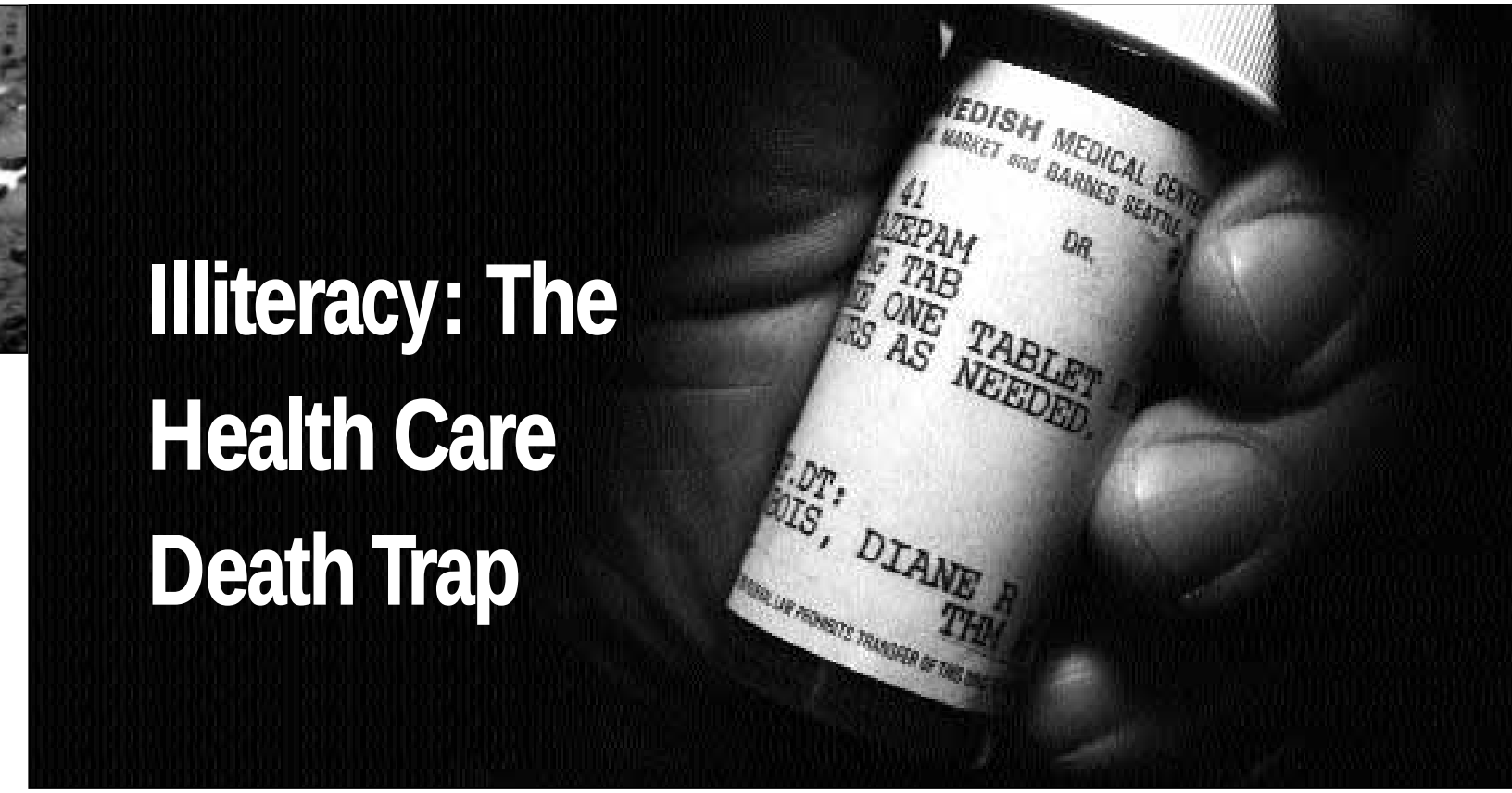
Illiteracy: The Health Care Death Trap



BY CONRAD F. MEIER

Many months ago, the popular TV show *ER* ran a sub-plot about a patient who died from an overdose of a prescribed medication. I expected to see lawyers invade the emergency room, demanding lawsuits for yet another alleged medical error.

I was stunned at the unexpected story line: The patient did not know how to read the instructions on the label, and had only a limited ability to understand the verbal instructions she was given.

Health care literacy—the ability to read, understand, and respond appropriately to health care information—is a key component for positive outcomes in medical care.

Concerns over health care literacy are not new; the matter was, for example, raised years ago, in the Spring 1998 issue of the *Pfizer Journal*, in an article titled "Responding to the Challenge of Health Literacy."

What Constitutes Literacy?

"Is someone who can read a sentence literate?" ask the *Pfizer* article's authors. "Not necessarily. Literacy has come to mean not only the ability to read or decode words, but also the ability to comprehend, understand, and use verbal reasoning to achieve objectives. The concept of functional literacy is also relatively new; it is based on the actual competency of people in performing tasks in everyday life."

The extent of the illiteracy problem in the U.S. is frightening. Notes the *Pfizer* article, "the 1993 National Adult Literacy Survey (NALS) estimated that some 40 to 44 million people could not read instructions on a prescription label, notes from a teacher, or directions on a map. An additional 50 million people are marginally literate."

Persons are considered functionally illiterate if they have no reading skills or read below fifth-grade level.

Data Speak Volumes

A 1993-94 NALS conducted in two public hospitals revealed:

- 23.6 percent of adults with inadequate health literacy did not know how to take medication four times a day. By contrast, 9.4 percent of adults with marginal health literacy, and 4.5 percent with adequate health literacy, were unable to understand the instruction.
- 81.1 percent of patients with inadequate health literacy did not understand the rights and responsibilities section of a Medicaid application. Thirty-one percent of those with marginal health literacy, and 7.3 percent with adequate health literacy, were unable to understand that part of the application.

In a 1995-96 study of the relationship between literacy and asthma knowledge, just 31 percent of asthma patients with third-grade reading skills knew they should see a doctor regularly, even when not having an asthma attack. For patients who read at between a fourth- and sixth-grade level, 63 percent understood the importance of seeing a doctor. Eighty percent of asthma patients with seventh- or eighth-grade reading skills, and 93 percent of those who read at the level of a high school graduate, understood the importance of regular doctor visits.

Studies of Medicare enrollees have identified similar relationships between literacy and health. In 1997, the Health Care Financing Administration (HCFA, now CMS, the Center for Medicare and Medicaid Services) studied Medicare enrollees living in a community setting (as opposed to a structured nursing home) and enrolled in a national managed care plan. The study revealed 54.3 percent with inadequate literacy levels did not know how to take medication on an empty stomach; 67.7 percent did not know how to interpret low blood sugar values.

A 1998 study by HCFA revealed only 20 percent of Medicare beneficiaries with an eighth-grade education reported they knew all or most of the Medicare information they need.

Wanted: Improved Communication

Health care illiteracy can be attributed to many factors, including the increasing failure of the U.S. education system to teach reading skills. (See, for example, "NAEP Reading Scores Tell a Grim Tale," *School Reform News*, June 2001.)

Literacy in the U.S. is on the decline, and until that changes health care providers and pharmacists must find ways to communicate effectively in a less-literate environment. That requires plain, easy-to-understand language—less medical jargon—and taking into account a patient's language proficiency, education level and age, as well as cultural, ethnic, and gender considerations.

It's especially important for health care practitioners to realize that literacy is an *individual* matter. Many people with low literacy skills do not fit common stereotypes. They can be well-dressed and articulate . . . and they are often ashamed of their inadequate literacy and won't acknowledge it.

In health care settings, this can be deadly. Persons in need of medical care may simply forego it, rather than ask for help. Others may pretend to understand what is being said to them. Still others may ask for the assistance of office staff, watch what other patients do or ask for their advice, or bring someone with them who does read. Health care practitioners need to be aware of their patients' literacy level and prepared to communicate with them at that level.

Free Market at Work

Literacy efforts abound in the United States. One aimed specifically at health care literacy is operated by Pfizer Pharmaceuticals. It has sponsored three high-level conferences on the topic, bringing together health care providers, academic researchers, employers, patient advocates, and public policy officials to develop policies and action strategies for change.

In addition, Pfizer annually awards two $75,000 grants, one for research to advance the understanding of health literacy and the other for an intervention program aimed at solving problems associated with health literacy.

"Pfizer's efforts are intended to generate new knowledge, create solutions, and increase the visibility of the health literacy problem in America," said Dr. George Flouty, Pfizer's medical director for public health programs. The company has developed its own set of "Health Literacy Principles" to ensure Pfizer patient communications materials are easy to read and understand.

"We've done a lot as a company to promote health literacy, but we also want to make sure our own house is in order," explained Dorothy Wetzel, Pfizer's director of consumer marketing and product management. "By 2002, our goal is for all new Pfizer patient communications materials to be written at the 6th grade reading level."

For more information…

WWW see the Spring 1998 issue of *The Pfizer Journal*, devoted to "responding to the challenge of health literacy." The entire issue is available on the Internet in Adobe Acrobat's PDF format at **http://www.thepfizerjournal.com/TPJ04.pdf.**

More information about the Pfizer Health Literacy Initiative is available on the Internet at **http://www.pfizerhealthliteracy.com/.**

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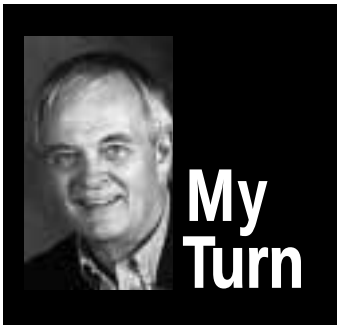

My Turn

"What Government Giveth, it Can Taketh"

BY CONRAD F. MEIER
MANAGING EDITOR

As work begins in the 2002 sessions, state legislators will have their hands full with two major issues: budgets awash in red ink, and homeland security issues related to the events of September 11, 2001.

Much of the health care debate will shift from state capitols to the nation's capitol. We should find it easier to keep an eye on the rascals in Washington than trying to keep up with 50 state legislatures. Rest assured, *Health Care News* will stay tuned-in and tuned-up for 2002.

If any significant legislation is to occur on patients' rights, Medicare and Medicaid reform, prescription drug discounts, and the uninsured, it will have to come from Washington. And even then, it could be all talk and no action.

Tight budgets at the state level are forcing some legislators to swallow hard and admit previous liberal fiscal policies on health care-related matters are wreaking havoc with state budgets. What state governments have given liberally, they now will take back, without apology. Some states residents are feeling a further pain in the wallet called income tax increases.

And, in the "I hate to say it, but I told you so," department, almost every state will be forced to revise, cut, or trim their budgets and tap into tobacco settlement funds to fill in general revenue gaps. A smaller and smaller share of that pie is going toward the health care-related issues that just two years ago "desperately needed funding." Such a surprise.

Budget Hemorrhage

Some 35 states are reporting they expect budget shortfalls this year. Among them:

- California, which is $12 billion short of sliding into the Pacific Ocean;
- New York, $3 billion short ... before 9/11;
- New Jersey, $1.9 billion;
- Virginia, $1.3 billion;
- Wisconsin, also at $1.3 billion;
- Indiana, $1 billion;
- Minnesota, also roughly a billion off the mark;
- Washington state, $800 million;
- Kentucky, $533 million; and
- Missouri, $324 million off (after reallocating 2002 tobacco funds).

Only 10 states have not reported shortfalls. Let's hear it for Alaska, Louisiana, Montana, Nevada, New Mexico, North Dakota, Oklahoma, Pennsylvania, Texas, and Wyoming. Possible shortfalls may yet be reported in Hawaii, North Carolina, and West Virginia.

"Ask Not What Government Can Do for You ..."

Hospitals and nursing facilities expect to see millions more dollars in operating losses through 2002 due to decreased Medicare and Medicaid reimbursements.

Governors around the country, struggling with bloated health care entitlements dished out during the last few years, now find it necessary to break faith and cut back public programs or severely ration services.

The economy, even if on the comeback trail, will not turn around fast enough to accommodate thousands of new Medicaid enrollees in states that have liberalized eligibility standards to include a family of three earning $50,000 a year.

Early last year, the American Public Human Service Association asked state Medicaid officials to report their projected budget increases for the fiscal year. Results were alarming: a 20 percent jump in Washington, 17 percent in Mississippi, 16 percent in Nebraska, 15 percent in North Dakota ... you get the idea.

And too, it's a critical time for nurses in the health care industry because of the projected shortage of professional nurses. Many hospitals are closing nursing units and downsizing staff in order to stay afloat.

"... Ask What You Can Do for Government"

Finally, the industry will soon be faced with a population demanding even more services. The bulk of working adults aged 30 to 50 are moving into the over-60 category, and right behind them are the young adults just starting families.

While today's population has generally been defined by a relatively predictable level of health care needs, tomorrow's population will have needs that are much less predictable ... except we know they'll be greater.

> **"By 2011, the first of the baby boomers will turn 65. If we think the pressure on the health care industry is heavy now, just wait."**

By 2011, the first of the baby boomers will turn 65. If we think the pressure on the health care industry is heavy now, just wait. As the population ages and people begin to have more ailments, it's not a time to be thinking about rationing services.

It is, instead, a time past-due for state and federal legislators to replace Medicare and Medicaid with private-sector insurance—not more government entitlement programs that trap people into government largesse and wreak havoc on state budgets.

It is also high time we looked at financing long-term care needs through private-sector long-term care insurance ... not Medicare, reformed or otherwise.

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